

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD MEETING

DAY 1

Arlington, Virginia

Thursday, September 4, 2008

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 PARTICIPANTS:

2 GREGORY A. POLAND, M.D.

3 COLONEL ROGER GIBSON

4 ELLEN EMBREY

5 MAJOR GENERAL GEORGE K. ANDERSON

6 RICHARDEEN BENJAMIN, Ph.D.

7 WILLIAM BLAZEK JR., M.D.

8 DAN G. BLAZER II, M.D.

9 MARK A. BROWN, Ph.D.

10 COLONEL (Ret.) ROBERT CERTAIN

11 BARBARA COHOON, Ph.D.

12 THOMAS DETRE, M.D.

13 RAYMOND F. DUBOIS

14 RICHARD ERDTMANN, M.D.

15 COMMANDER EDMOND FEEKS

16 CHARLES FOGELMAN, Ph.D.

17 PIERCE GARDNER, M.D.

18 WILLIAM E. HALPERIN, M.D.

19 BRIGADIER GENERAL (Ret.) JAMES J. JAMES

20 LISA JARRETT

21 EDWARD L. KAPLAN, M.D.

22 JAMES P. KELLY, M.D.

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 PARTICIPANTS (CONT'D):

2 MAJOR GENERAL JOSEPH E. KELLEY

3 KENNETH W. KIZER, M.D.

4 WAYNE LEDNAR, M.D.

5 MARK A. MILLER, M.D.

6 COLONEL ROBERT L. MOTT

7 FLORABEL G. MULLICK, M.D.

8 CAPTAIN NEIL NAITO

9 DENNIS S. O'LEARY, M.D.

10 MICHAEL N. OXMAN, M.D.

11 MICHAEL D. PARKINSON, M.D.

12 JOSEPH E. PARISI, M.D.

13 COMMANDER ERICA SCHWARTZ

14 ADIL E. SHAMOO, M.D.

15 PATRICIA SHINSEKI

16 JOSEPH SILVA JR., M.D.

17 COMMANDER CATHERINE SLAUNWHITE

18 HONORABLE CHASE UNTERMEYER

19 DAVID H. WALKER, M.D.

20 HONORABLE TOGO WEST

21 GAIL WILENSKY, Ph.D.

22 * * * * *

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 P R O C E E D I N G S

2 DR. POLAND: Good morning, everybody.

3 Welcome to this meeting of the Defense Health
4 Board, and I want to extend a special welcome to a
5 number of our new board members who are around the
6 table. I haven't even gotten to meet all of them
7 but certainly know them by name and by reputation.
8 We have a number of important topics on our agenda
9 today, so we'll get started and I'll ask Ms.
10 Embrey to call the meeting to order.

11 MS. EMBREY: Thank you, Dr. Poland. As
12 the Designated Federal Official for the Defense
13 Health Board, a Federal Advisory Committee and a
14 continuing independent scientific advisory body to
15 the Secretary of Defense via the Assistant
16 Secretary of Defense for Health Affairs and the
17 Surgeons General of the Military Departments, I
18 hereby call this meeting of the Defense Health
19 Board to order. Dr. Poland?

20 DR. POLAND: Thank you. We started a
21 tradition of our board, and that is at the
22 beginning of each meeting I would ask that all of

1 us stand for 1 minute of silence to honor those
2 who we are here to serve, the men and women of our
3 armed forces.

4 (Minute of silence.)

5 DR. POLAND: Thank you all very much.
6 We have a number of distinguished guests with us
7 this morning but I particularly want to
8 acknowledge Mr. Bob Foster and Admiral Smith. And
9 I would also like to provide an update on one of
10 our board members, Brigadier General Retired Dr.
11 Bill Fox whom a number of you met. He was on our
12 board for several meetings and is a member on the
13 Panel On the Care of Individuals with Amputational
14 and Functional Limb Loss. As most of you are
15 aware, Bill was seriously injured in an IED blast
16 in Iraq last year while carrying out a mission for
17 Project HOPE and I'm happy to report that his
18 condition has dramatically as we hear it and he
19 has enthusiastically expressed the desire to
20 return to the board so that he can share his
21 thoughts and make continuing contributions toward
22 improving health care for our wounded service

1 members particularly given his new perspective and
2 his unfortunate experience. He is especially
3 hopeful to be able to give input and to contribute
4 in the area of traumatic brain injury and looks
5 forward to returning to the board in the near
6 future, and when he does if you'd please give him
7 a warm welcome as I know you will.

8 I'd like to remind everybody that this
9 is an open session and as we start I'd like to go
10 around the table and have the board and
11 distinguished guests introduce themselves. For
12 the new core board and subcommittee members, if
13 you could just give us three or four sentences
14 about yourself so we can begin to know you and
15 what your skill sets and experience have been.
16 I'll ask Ms. Embry to start.

17 MS. EMBRY: I'm Ellen Embry. In my day
18 job I'm the Deputy Assistant Secretary of Defense
19 for Health Affairs with a focus on force health
20 protection and readiness, and I'm the Designated
21 Federal Official for this board and its
22 committees.

1 DR. WILENSKY: My name is Gail Wilensky.
2 I'm a Senior Fellow at Project HOPE. I finished a
3 stint a short time ago as the co-chair for a
4 congressionally mandated taskforce on the future
5 of military health care. I was also privileged to
6 be one of the commissioners on the President's
7 Commission on the Care of Returning Wounded
8 Warriors, the so-called Dole-Shalala Commission,
9 and earlier in the decade co-chaired a taskforce
10 that the president set up to improve health care
11 for our nation's veterans which focused on trying
12 to better align the transition from active duty to
13 veteran status. I am delighted to have an
14 opportunity to make use of the knowledge and
15 experience I gained in these various taskforce
16 activities with the Defense Health Board which I
17 had the pleasure to speak before twice when we
18 were presenting our interim and final report last
19 year. So it's a pleasure to be on this side of
20 the fence.

21 MR. LEDNAR: I'm Wayne Lednar. I'm the
22 Global Chief Medical Officer for DuPont.

1 COLONEL CERTAIN: I'm Robert Certain.
2 I'm an Episcopal Priest in Marietta, Georgia.

3 DR. JAMES: Jim James. I'm with the
4 American Medical Association. I was 26 years with
5 the Army Medical Department, retiring as the
6 Medical Center Commander back there in 1996 in El
7 Paso. Following that I was with the dark side
8 doing managed care, went on to Miami Dade where I
9 was the Public Health Director during anthrax,
10 9/11, and those things, and from there went to the
11 American Medical Association where I've been for
12 about 5 to 6 years focusing on educational
13 programs and disaster response and the editor in
14 chief of the newly published "Disaster Medicine
15 and Public Health Preparedness" journal. Thank
16 you.

17 DR. WALKER: I'm David Walker, Professor
18 and Chair of the Department of Pathology,
19 University of Texas Medical Branch at Galveston.

20 DR. DETRE: Thomas Detre, a psychiatrist
21 interested in psychopharmacology and research,
22 former President of the University of Pittsburgh

1 Medical Center.

2 DR. SILVA: I'm Joseph Silva, Professor
3 of Medicine and Microbiology and Dean Emeritus of
4 the School of Medicine, University of California,
5 Davis.

6 DR. BENJAMIN: I'm Richard Benjamin,
7 the Chair of the School of Nursing at Old Dominion
8 University in Norfolk, Virginia. My background is
9 in psychiatric mental- health nursing and I also
10 had some experience in psychiatric epidemiology.
11 Dr. Detre is from a place where I completed my
12 fellowship at the Western Psychiatric Institute
13 and Clinic in Pittsburgh.

14 DR. OXMAN: I'm Dr. Mike Oxman, a
15 Professor of Medicine and Pathology at the
16 University of California in San Diego, a board
17 member, and a virologist.

18 REAR ADMIRAL SMITH: I'm Dave Smith.
19 I'm the Joint Staff Surgeon and Medical Adviser to
20 the Chairman.

21 DR. BLAZER: I'm Dan Blazer. I'm a
22 psychiatrist in epidemiology from Duke. By the

1 way, we won a football game this year so I just
2 wanted to get that on the board. I want that in
3 the record, by the way. I have been on the board.
4 I may be one of the longest-term members, perhaps
5 one of the first mental-health people who's been
6 on this board and it came at a very important
7 time, and I also served on the Taskforce on Mental
8 Health. It's good to see other mental-health
9 people here.

10 DR. KAPLAN: I'm Ed Kaplan, Professor of
11 Pediatrics at the University of Minnesota Medical
12 School, in Minneapolis, and a board member.

13 GROUP CAPTAIN: Good morning. I'm Group
14 Captain Alan Cowan. I'm the British Liaison
15 Officer to two organizations. The first is the
16 Veterans Administration where I spent part of my
17 week, and the balance is with Ms. Embrey's staff
18 in FHPNR where I spend probably the larger part of
19 my week looking broadly at the whole deployment
20 health field and looking at what goes on in the
21 veterans' area to see what U.K. can learn and what
22 we can share with you, and equally looking at what

1 goes on in the active population to see what's
2 good and what's bad there and how we do better.
3 I've been here 2 weeks, so treat me gently.

4 LIEUTENANT COLONEL GOULD: Phil Gould,
5 Chief of Preventive Medicine at the Air Force's
6 Medical Operations Agency, soon to be the Air
7 Force AFMSA Support Activity.

8 LIEUTENANT COLONEL BLEDSOE: Yolanda
9 Bledsoe, Joint Staff Health Services Support
10 Division. So, sitting in for Colonel Silva but
11 work with Admiral Smith over there.

12 COLONEL MOTT: Bob Mott, preventive
13 medicine at the Army Surgeon General's Office.
14 I've been there for about 2 months. Before that I
15 was the Director of the Division of Preventive
16 Medicine at the Walter Reed Army Institute of
17 Research. I first came to the AFEB as a resident
18 back in 1995, so it's very nice to be on the
19 board.

20 COMMANDER SCHWARTZ: Erica Schwartz, the
21 Coast Guard Preventive Medicine Liaison at Coast
22 Guard headquarters.

1 serve presently at the Center for Clinical
2 Bioethics at Georgetown. I'm an practicing
3 internist and I'm a retread infantryman.

4 MS. SHINSEKI: I'm Patty Shinseki and I
5 sit on the Panel for Amputee and Limb Loss. I am
6 really a military spouse of 38 years and my
7 husband is an amputee, so I am hopefully bringing
8 the perspective of the family and the spouses in
9 recovery and rehabilitation. I also chair the
10 Military Child Education Coalition's initiative
11 called Living in a New Normal: Supporting Children
12 Through Trauma and Loss.

13 DR. KELLY: I'm Jim Kelly. I'm a
14 neurologist at the University of Colorado School
15 of Medicine with a career interest in traumatic
16 brain injury. I chair the Traumatic Brain Injury
17 External Advisory Subcommittee, and I'll be giving
18 a report to the board this morning.

19 DR. HALPERIN: Bill Halperin, board
20 member. I'm Chair of the Department of Preventive
21 Medicine at the New Jersey Medical School in
22 Newark, and Chair of the Department of

1 Quantitative Methods in the School of Public
2 Health in Newark.

3 DR. SHAMOO: Adil Shamoo, board member,
4 Professor of Biological Chemistry and Molecular
5 Biology. I'm a bioethicist.

6 DR. ERDMAN: My name is Rick Erdman.
7 I'm the Staff Liaison Member from the Institute of
8 Medicine, part of the National Academies. I'm a
9 former military officer, Army, preventive medicine
10 trained. Just happy to be here.

11 DR. PARISI: Good morning. I'm Joseph
12 Parisi. I'm a pathologist at the Mayo Clinic in
13 Rochester, Minnesota, where my specialty is
14 neuropathology. I'm a board member and Chair of
15 the Subcommittee on Pathology and Laboratory
16 Services for the Defense Health Board, and it's a
17 pleasure to be here.

18 DR. PARKINSON: Good morning. I'm Mike
19 Parkinson. I am a board member and Chair of the
20 newly formed Health Care Delivery Subcommittee. I
21 spent 20 years in the Air Force, a lot of time
22 thinking about how to reorganize the direct

1 delivery system and the purchase care in my latter
2 years. I was one of the founders of Lumenos, one
3 of the nation's consumer-driven health plans that
4 was acquired by WellPoint and served 2 years as
5 the medical director with WellPoint.

6 DR. O'LEARY: I'm Dennis O'Leary, a new
7 board member and I'm very pleased to be here. I'm
8 retired from the Joint Commission and I served as
9 president there for 21 years. The Joint
10 Commission has historically had a long
11 relationship with the Department of Defense.
12 Before I was at the Joint Commission I was at
13 George Washington Medical Center as the Medical
14 Director of the University Hospital and Dean for
15 Clinical Affairs and Professor of Medicine. I'm
16 really looking forward to this experience.

17 MR. DUBOIS: I'm Ray DuBois. I am a
18 resident senior adviser at the Center for
19 Strategic and International Studies here in
20 Washington. I am a new member of the NCR BRAC
21 Health Systems Advisory Committee. And some of
22 you may remember that I was the fellow you brought

1 you BRAC, as it were, having designed and managed
2 the BRAC process in the department, BRAC
3 2005/2006. I was also the former Director of
4 Administration and Management of the Office of the
5 Secretary of Defense otherwise known on good days
6 as the mayor of the Pentagon and had been for over
7 a year the Acting Under Secretary of the Army.

8 MR. UNTERMEYER: Good morning. I'm
9 Chase Untermeyer. I'm a new member of the board.
10 I am in private business in Houston but I've had a
11 military connection going back exactly 40 years.
12 About this time 40 years ago I was a junior
13 officer aboard a destroyer in Vietnam, and in
14 later years in the Reagan administration I was
15 Assistant Secretary of the Navy for Manpower and
16 Reserve Affairs in which I dealt quite extensively
17 on the subject of the Naval Health Care System.
18 And then most recently I was U.S. Ambassador in
19 Qatar where of course we have major military
20 operations, primarily the Al-Uedid Air Base, and
21 it was great thrill to be reconnected to the
22 military and try to help the Central Command in

5 DR. POLAND: My name is Greg Poland.

17 CAPTAIN BUTLER: Good morning. My name
18 is Frank Butler, a 30-year medical officer
19 currently serving as Chairman of the Tactical
20 Combat Casualty Care Committee which we'll be
21 talking about shortly.

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 Cordts. I'm Director of Health Policy and
2 Services at the Office of the Army Surgeon
3 General.

4 MR. CAMPBELL: Good morning. I'm Stuart
5 Campbell and I'm the U.K. Liaison Officer at the
6 Office of the Army Surgeon General.

7 DR. COHOON: Barbara Cohoon. I'm the
8 Deputy Director of the National Military Family
9 Association. I handle health care for them and I
10 have my doctorate in health policy.

11 MR. MONFORT: I'm Charles Monfort,
12 former Deputy Assistant Secretary of Defense for
13 Health Affairs and now a consultant on health
14 care.

15 COMMANDER CLASS: I'm John Class, Deputy
16 Director for Government Relations, Health Affairs,
17 at the Military Officers Association.

18 DR. KRUKAR: I'm Michael Krukar, a
19 preventive medicine resident at Uniformed
20 Services.

21 MR. MOORE: Thomas Moore, also a
22 preventive medicine resident at USIS.

1 MR. RUSSELL: Kevin Russell, new
2 director of GEIS and Deputy Director of the Armed
3 Forces Health Surveillance Center.

4 MR. BALABAN: I'm Carey Balaban. I'm
5 Professor of Otolaryngology and Neurobiology
6 Communication Science and Disorders and
7 Bioengineering at the University of Pittsburgh.
8 I'm also Director of the Center for National
9 Preparedness.

10 MS. EICK: Angie Eick, Deputy Scientific
11 Director at the Armed Forces Health Surveillance
12 Center.

13 MR. RIDGELY: I'm Rabold Ridgely, 30
14 years at the Armed Forces Institute of Pathology.

15 MR. LUKEY: I'm Brian Lukey from Medical
16 Research Materiel Command.

17 MR. FOSTER: I'm Bob Foster. I work for
18 the Under Secretary of Defense for Acquisition.
19 I'm the guy who's responsible for medical research
20 in the Department of Defense.

21 MR. MARTIN: I'm Chris Martin. I'm a
22 research fellow at the Armed Forces Health

1 Surveillance Center.

2 MS. NYALTRO: I'm Jody Nyaltro, and I'm
3 the Washington representative for Gold Star Wives.

4 MS. KIDD: I'm Silvia Kidd. I'm
5 Director of Family Programs for the Association of
6 the United States Army.

7 MS. JEFTS: Barbara Jefts, Healthcare
8 Delivery Division Chief at JTF CAPMED.

9 MR. BIDDLE: Tim Biddle, Deputy Chief,
10 Medical Center, National Security Agency.

11 DR. THOMPSON: I'm Donald Thompson, a
12 preventive physician. I work at the Department of
13 Defense Inspector General's office.

14 MR. BURNETT: Dan Burnett. I'm
15 Director, General Preventive Medicine Residents at
16 USIS.

17 MR. COURTNEY: I'm Bill Courtney. I'm
18 the Chair of the Public Health Department at the
19 School of Aerospace Medicine, formerly known as
20 AFIOH.

21 MR. SKVORAK: I'm John Skvorak. I'm
22 Commander, USAMRID, at Fort Dietrich.

1 DR. KITCHEN: Lynn Kitchen, Deputy
2 Director, Military Infectious Disease Research
3 Program. I am an infectious disease physician.

4 LIEUTENANT COLONEL JAFFEE: I'm Mike
5 Jaffee. I'm the National Director of the Defense
6 and Veteran's Brain Injury Center and I'm serving
7 as the DOD liaison to the Subcommittee on
8 Traumatic Brain Injury as well as the Subcommittee
9 on the TBI Family Caregiver Program.

10 MR. WIGGINTON: I'm George Wigginton.
11 I'm national account director with Merck and
12 Company with responsibility for DOD and VA.

13 COMMANDER FEEKS: I'm Commander Ed
14 Feeks, Preventive Medicine Officer at
15 Headquarters, Marine Corps.

16 DR. POLAND: We've already gone around,
17 so any of the new board members who came a bit
18 later, if you'd please introduce yourselves.

19 MR. FOGELMAN: My name is Charles
20 Fogelman, and I'm on the Psychological Health
21 External Subcommittee. If you want a lot more
22 detail, I can tell you that I'm the guy who

1 thought it was a lot shorter walk from the subway
2 than it actually was.

3 MS. JARRETT: Lisa Jarrett, CCSI
4 contractor, Defense Health Board.

5 COMMANDER EICHERT: Commander Eichert,
6 also at CCSI.

7 DR. MILLER: Mark Miller, Associate
8 Director for Research and Director of Epidemiology
9 and Population Studies at the Fogerty
10 International Center, NIH, with background in
11 mathematical modeling and computational biology of
12 infectious diseases and vaccine development.

13 DR. POLAND: Did we have anybody else
14 join us who has not introduced themselves?

15 For the new board members, typically
16 what we'll do, and you'll see this repeatedly, is
17 we'll have a briefing that may be informational,
18 it may be a question to the board, or it may be a
19 report of activities. When our board was smaller
20 we would then have discussion and we'll still have
21 that. It was hard to stay on time then and I'm
22 suspecting it will be a little harder with a

1 larger board, so forgive me if I have to cut
2 discussion short in the interests of getting
3 through the amount of material we typically do at
4 our semiannual meetings. Roger, I think you have
5 some other comments to make.

6 COLONEL GIBSON: I want to thank the
7 Sheraton Crystal City Hotel for helping with the
8 arrangements for this meeting and my staff with
9 Ms. Jarrett in the lead for arranging the meeting
10 and arranging your travel, et cetera, and of
11 course to Ms. Ward back home who is ever present
12 and very diligent in her efforts.

13 One of the requirements of a Federal
14 Advisory Committee is signing the attendance
15 roster, so please do that. It's important that we
16 keep track of the folks who come to this meeting.
17 For those of you not seated at the table, we have
18 handouts for all of the presentations today.
19 Administration, bathrooms outside to the left. We
20 have light refreshments at the end of the hallway.
21 Take another left and there's a room there with
22 coffee and light refreshments.

1 For those of you who need telephone,
2 fax, et cetera, see Ms. Jarrett. And because this
3 is an open meeting, it's being transcribed. So it
4 is important for our court reporter to know who
5 says what and when. So please introduce yourself
6 if you have any comments so that she can capture
7 the name as part of the discussion. And speak
8 clearly into the microphones. I notice we have a
9 couple of them that are a little problematic, so
10 try to speak as clearly as you can into the
11 microphone.

12 CME credits are offered for this
13 meeting. The forms for the board members are in
14 the books. We have additional forms. Ms. Jarrett
15 can provide details on that.

16 Finally, the next meeting is tentatively
17 scheduled for December of this year. The board
18 will decide on exact dates and location during the
19 administrative session and at that meeting we'll
20 receive again updates from our subcommittees. As
21 Dr. Poland discussed, the core board sits in a
22 strategic position to take questions from the

1 Department of Defense. We have a series of
2 subcommittees, several subcommittees, and as those
3 questions come in they will be assigned to
4 subcommittees for due diligence, research,
5 discussion, before coming back to the board for
6 deliberation of reports and recommendations. With
7 that, back to you, sir.

8 DR. POLAND: A couple of other things.
9 If I could ask the new members of the core board
10 or subcommittee to have lunch with me in the same
11 room that we'll have lunch in, but if we wouldn't
12 mind sitting together so I can sort of get to know
13 you a little bit and answer questions about the
14 board, that would be nice. Also in the notebook
15 under Tab 1 are brief bios on our new members.
16 Finally, I'd like to acknowledge and thank Ms.
17 Embrey and Colonel Gibson. This evening for the
18 current board members there will be an award
19 ceremony, the Secretary of Defense Award for
20 Outstanding Achievement for our board members
21 which I think is an appropriate recognition of the
22 time and effort that you've put in. And as I

1 understand it, Dr. Cassells will present those at
2 our dinner meeting so be sure that you do attend
3 that.

4 COLONEL GIBSON: I'll pass around a
5 roster to sign up for the meeting tonight.

6 DR. POLAND: Our first speaker this
7 morning is retired Capitan Dr. Frank Butler who's
8 currently serving as a medical consultant to the
9 Navy Medical Lessons Learn Center, as well as an
10 Adjunct Professor of Military and Emergency
11 Medicine. As Chairman of the Committee on
12 Tactical Combat Casualty Care, he will provide the
13 board with an update on the Trauma and Injury
14 Subcommittee and brief the board on combat
15 casualty care. The Trauma and Injury Subcommittee
16 has just recently stood up, but its members have
17 been meeting for some time and discussing issues
18 associated with combat casualty care. The board
19 believes trauma and injury treatment and
20 prevention should be a DOD core competency and is
21 thrilled to have the members of this subcommittee
22 participate in ensuring that such efforts

1 optimally meet the needs of our service members.
2 His presentation slides can be found under Tab 2
3 of the meeting binders. Dr. Butler, the floor is
4 yours.

5 CAPTAIN BUTLER: Thanks. I'd like to
6 start with just a brief word of explanation about
7 why the ophthalmologist in the crowd is up here
8 talking about trauma as opposed to the usual eye
9 trauma which is corneal abrasions and things like
10 that. I started my Navy career, I spent 4 years
11 as a Navy SEAL platoon officer and when I went
12 back to medical school I was fortunate enough to
13 be able to spend the majority of my 26 years in
14 Navy medicine supporting our SEALs and our other
15 Special Operations forces. So that leads you down
16 some different roads and this is one of the roads
17 that it led down.

18 If you are shot in the Washington, D.C.
19 area, the good news is when you go to the
20 emergency room this is what your care will be
21 like. It will be air conditioned unless you're in
22 Florida and there's a hurricane. The lights will

1 be on. You'll have a skilled trauma team. You'll
2 have all of the equipment that you could imagine
3 at the service of your trauma team, and you will
4 receive the best trauma care in the world.

5 Take a second to picture yourself in the
6 setting where our combat medics have to take care
7 of combat trauma. This is a shrapnel wound to the
8 hip. It's a little tough to tell from the
9 perspective. The setting, I took this picture at
10 8,000 feet in the Hindu Kush in 2003. This is
11 where our medics were having to sustain these
12 casualties, treat them with only the equipment
13 they carried in on their backs in the dark and
14 wait for the helicopter that was going to be
15 delayed for 10 hours because of the snow storm.
16 So it's intuitive that we have to have a somewhat
17 different set of management strategies for this
18 circumstance. The problem has been that this has
19 sometimes been difficult to do and I want to show
20 you a dramatic example of how it's been difficult
21 to make this transition from the civilian mindset
22 to where our combat medics live. This is a paper

1 that was written by a young Army major in World
2 War II and it dealt with tourniquets. He said, We
3 believe that the strap and buckle tourniquet that
4 the Army is issuing us right now does not work and
5 needs to be replaced. That's really
6 straightforward advice, and this was published in
7 the Army Medical Department Journal. So
8 fast-forward if you will 25 years to the Vietnam
9 War. In the aftermath of that war, we realized
10 that over 2,500 deaths had occurred in casualties
11 who had no other injuries except for extremity
12 trauma. They bled to death from their arms or
13 legs when a tourniquet would have saved them. So
14 in those 25 years between World War II and Vietnam
15 we've not been able to sort this out.

16 So you think this is a painful lesson.
17 We've got it now. Wrong. In the mid-1990s, the
18 same strap and buckle tourniquet that was being
19 issued in World War II was still being issued.
20 Worse, we were sending our medics to civilian
21 trauma care courses where the doctrine was not to
22 use tourniquets. So we give them tourniquets and

1 we send them to courses where they're told not to
2 use them. Not surprisingly, when the war started,
3 we had some issues. A few papers that came out
4 looking at the epidemiology of trauma deaths at
5 the start of the war had some bad numbers. When I
6 was at the Special Operations Command as a
7 surgeon, in 2004 I directed that we look at all of
8 our first 82 casualties. We went to the Armed
9 Forces Institute of Pathology and the people there
10 helped us tremendously. We pulled all 82 of those
11 autopsy reports to see who could have been saved
12 and who was unavoidably going to die from their
13 injuries. So what we found was that of the 82
14 deaths that we reviewed, 12 of them were
15 potentially survivable injuries and three could
16 have been saved with nothing more high tech than a
17 tourniquet on their arm or leg, and this is a
18 picture of one of these soldiers. This gentleman
19 bled to death from a wound below his knee and you
20 will see that this was in 2004, we did not have
21 tourniquets. These guys tore up T-shirts and used
22 paint brushes out of their ammo kit to try to

1 construct a field-expedient tourniquet.

2 Another paper that came out more
3 recently but still focuses on the 2004 period was
4 published by Al Beekley from Madigan, a trauma
5 surgeon at the Combat Support Hospital in Iraq.
6 They looked at 165 casualties with extremity
7 trauma and found that a little less than half of
8 them had tourniquets, there were seven deaths in
9 this cohort, and four of those seven deaths could
10 have been prevented with nothing more than a
11 tourniquet.

12 Those are really not acceptable numbers.
13 Back in the early 1990s the special operations
14 community put together a research project where we
15 started to rethink this and try to say, What can
16 we do better? How can we save these preventable
17 deaths? We drew heavily on the data that was
18 generated by the Army. Colonel Ron Bellamy was a
19 trauma surgeon in Vietnam. We looked at his data
20 and we looked at number like this, 9 percent of
21 the killed in action from Vietnam had only
22 extremity wounds, savable lives. Likewise,

1 tension pneumothorax, 5 percent of the killed in
2 action were people who had a tension pneumothorax
3 which is easily treatable. Some other causes of
4 death there was really nothing we could do about.
5 If you're shot in the head, sadly you're shot in
6 the head and there's nothing the medic can do to
7 help you, so we focused on the preventable deaths
8 that were out there.

9 As the three principles of tactical
10 combat casualty care, we had to bear in mind that
11 when you're in hospital emergency room, the
12 casualty, the patient, is the mission. When
13 you're out in the field, you have the casualty and
14 the mission. The mission doesn't go away because
15 you've got a casualty. You've got to deal with
16 both the casualty and your tactical flow at the
17 same time. So we have to treat the casualty but
18 we have to bear in mind that we want to prevent
19 additional casualties and we have a job to do for
20 our boss out there which was important enough for
21 him to put young men and women's lives at risk to
22 start with. We've got to get that job done.

1 One of the first things that developed
2 was the concept that we had to look at the timing
3 of the interventions. You don't stop and do a
4 complete ATLS secondary survey while there's still
5 a gunfight going on. There are things that are
6 appropriate to do for care under fire, there are
7 things that are appropriate to do once the
8 fighting has stopped but you're still in the field
9 waiting for the helicopter. And then there are
10 some additional things that you can do once you're
11 on the helicopter, and this is a great example of
12 this. This is a well-known picture of Sergeant
13 Major Brad Cassells. He was wounded 14 times, but
14 you see his weapon here. He was still in the
15 middle of a gunfight and sometimes the tactical
16 issues take precedence over the casualty issues.

17 With this research effort we had a
18 tremendous team from both the military and tons of
19 civilian trauma experts come in. We decided that
20 tourniquets were something that despite the
21 civilian teachings at the time we had to go back
22 into and advocate for very heavily. Our medics

1 have to be able to put needles in chests and
2 decompress tension pneumothorax. If you have
3 somebody who's unconscious, don't try to intubate
4 them, just put a nasopharyngeal airway in there.
5 That will probably do very well. When you look at
6 the risks of having a 19-year-old medic who
7 doesn't do a lot of trauma care do his first
8 intubation in the dark on the battlefield, it's a
9 very dicey proposition. If you do have somebody
10 who's shot in the face and a nasopharyngeal airway
11 is not enough, then what he really needs is a
12 surgical airway and so that restructured the way
13 that we teach airway. Technically appropriate
14 fluid resuscitation, don't start I.V.'s on
15 everybody because it takes time and it uses up
16 your precious supplies. If you don't need an
17 I.V., you don't get an I.V. We used a different
18 fluid than the civilians used because of our
19 prolonged evacuation time, battlefield
20 antibiotics, better analgesia, combining the
21 tactics with the medicine, basing the casualty
22 response to the individual tactical scenario that

1 you had to deal with. And lastly and very
2 importantly, getting combat medics to the table,
3 not just the doctors who've never been out in the
4 field.

5 In 1996 those came out. Some of you
6 were here at some of the eagerly briefings. Sort
7 of sat there. The only people who really did
8 anything with these guidelines were the SEALs and
9 the Rangers. But they liked them very much and
10 after about 5 years the Special Operations Command
11 had started to use them more and we realized we
12 needed a way to update these guidelines. Nothing
13 is medicine is static and that includes the
14 prehospital part of it as well. So we took U.S.
15 SOCOM money and an offer of help from the Navy
16 Operational Medicine Institute and founded the
17 Committee on Tactical Combat Casualty Care. Even
18 though it was a Navy-run organization, we had
19 people from all services. We had trauma surgeons,
20 we have emergency medicine docs, critical care
21 physicians, operational physicians, medical
22 educators, and the combat medical personnel who

1 actually were going to use these techniques and
2 put them all at the table.

3 It's worth just briefly mentioning some
4 of the people who we have on the committee. We
5 had Admiral Carmona when he was the Surgeon
6 General of the U.S. Not everybody knows that he
7 was an old Special Forces medic, but he offered to
8 help us. We had the Chairman of the American
9 College of Surgeons Committee on Trauma, five
10 members of his Committee on Trauma. We had the
11 trauma consultants for the Army and the Air Force
12 Surgeons General, command surgeons from U.S.
13 SOCOM, a senior enlisted medical adviser for
14 SOCOM, the command surgeon and the senior medic
15 for the Rangers, and several trauma directors for
16 level one trauma centers. So it's a good mix of
17 professional expertise, and we all would sit
18 around the table like this and just hash these
19 issue out.

20 That group was responsible for the
21 updates which came out in 2003 and 2006, and the
22 major innovations with the updates were the new

1 hemostatic agents at the time, Heem Con and Quick
2 Clot. Intraosseous infusion devices. It's
3 sometimes really hard to start an I.V. on somebody
4 in shock, but you always know where his sternum is
5 and we are now fielding these intraosseous
6 devices. They've had great success. We need
7 antibiotics but they don't have to be
8 intravenous. The fourth- generation
9 floroquinolones have excellent coverage and good
10 bio availability when taken orally. We changed
11 our fluid resuscitation strategy based on a joint
12 conference held by the Army and the Navy and now
13 do hypotensive resuscitation with Hextend. We
14 changed our antibiotic from what it had been
15 previously. Thanks to the work of John Holcomb
16 and others at the Institute of Surgical Research
17 we started to develop a better appreciation for
18 how our casualties were getting hypothermic and
19 how that was contributing to the coagulopathy of
20 trauma that was increasing the mortality rate.
21 That is something also that we can turn around,
22 and actually Health Affairs signed that out as a

1 policy letter and it's now being practiced on the
2 battlefield. We are wrapping these casualties up
3 even when they're shot in Iraq to keep them from
4 getting hypothermic. Lastly, management of
5 wounded hostile combatants. That is a very
6 sensitive topic and that needs to be done
7 correctly and we've published some guidelines for
8 that.

9 As I mentioned, when these guidelines
10 first came out it was SEALs and Rangers and just a
11 few unit-based initiatives in the Army, largely in
12 the Special Forces community, and the Marine
13 Corps. One of the big steps that happened was the
14 Army 91W school picked up these concepts in the
15 year 2000 so the Army was a little bit ahead of
16 the game than the other services but it wasn't
17 really until the war started that SOCOM, the PJs,
18 the Marines, the Coast Guard, and the Navy had a
19 policy statement saying that, yes, we are going to
20 use these guidelines, the early reports coming in
21 from the war are indicating that they're working.
22 At this point they were already also used by the

1 FBI, the CIA, Canada, and most of our NATO allies.
2 So the visibility has increased over what it used
3 to be. That's helped from the standpoint of the
4 committee's support. Mr. Thresher from the
5 Army's Surgeon General's Office in the fall of
6 2007 said we would like to help fund your
7 activities and we liked for him to help fund our
8 activities too and so we are now jointly supported
9 by the Army and the Navy Surgeons General. With
10 the increasing visibility and the joint
11 applicability, Navy medicine asked the question in
12 October 2007 should the committee be located
13 somewhere other than Echelon 5 Navy Command.
14 Maybe it needs to be at a more senior command and
15 a place with joint representation. So this
16 presented to Ms. Embrey staff and Admiral Smith's
17 staff and on 3 March we got the notice that we
18 were going to be relocated. Colonel Gibson came
19 down and talked to us at our April meeting and
20 said you guys now belong to the Defense Health
21 Board.

22 That's what has happened. I would like

1 to use the remaining 5 minutes to show you some of
2 the evidence that's coming in. I know this is a
3 group that wants to see evidence so let's go back
4 and look at tourniquets. Did we do the right
5 thing or the wrong thing by pushing tourniquets
6 when the civilian sector at the time wasn't? So
7 this is the tourniquet that we're using. The
8 combat application tourniquet is in widest use.
9 These are two other varieties that have also been
10 used with some success. So these are an example
11 of where tourniquets are invaluable and this
12 happened again to my unit when I was in
13 Afghanistan. We had a guy who was in a vehicle
14 that was struck by a rocket-propelled grenade.
15 There were three casualties. Our corpsman went
16 in, pulled the casualties out of the burning car.
17 One had fatal abdominal wounds and died. Two
18 others had severe lower-extremity bleeding, and
19 both got tourniquets and both survived without any
20 complications from the tourniquets. In the drive
21 on Baghdad, one of the Army battalion surgeons who
22 was there said that tourniquets played a decisive

1 role in quickly and effectively stopping
2 hemorrhage under fire and keeping the soldiers
3 alive until they got to the hospital. And given
4 the battle conditions under which these casualties
5 occurred, there's no way for these guys to sit
6 there and try to hold direct pressure on these
7 bleeding extremities as their unit is maneuvering.

8 The Israelis published a bit larger
9 study in 2003 looking at 91 battlefield
10 applications with good success as you see here and
11 very few complications. Most of them were minor
12 and transient peripheral neuropathies. A large
13 tourniquet paper just came out this year from the
14 combat support in Baghdad by Colonel Craig from
15 BAMSE. He was at the combat support in Baghdad
16 with 232 patients with tourniquets on 309 limbs,
17 no amputations, many lives saved was what they
18 concluded at the end of that paper. And again, a
19 very low incidence of transient nerve palsies.

20 I'm going to skip ahead to this slide.
21 What are the combat medics saying about this? In
22 a paper from Madigan, of the medics that they had

1 trained in TC3 who had gone to war and actually
2 treated casualties, 99 percent said that their TC3
3 training was a major help in managing their
4 casualties. Al Beekley in publishing his lessons
5 learned from the war paper highlighted 19 major
6 advances in medical care that had come out of the
7 war and nine of those were related to tactical
8 combat casualty care. John Holcomb and Howard
9 Champion documented that the survival of our
10 casualties is the highest in this conflict it's
11 ever been and they list tactical combat casualty
12 care as one of the major factors. A special
13 supplement published in AMSIS, the Navy Surgeon
14 General directed review of this topic and found
15 that all the military was using TC3, numerous
16 reports of lives saved with no conceptual
17 deficiencies.

18 The last two slides. This slide is from
19 Dr. Jeff Salamon. He is the prehospital chair for
20 the American College of Surgeon's Committee on
21 Trauma and they are the people who publish the
22 PHTLS manual and endorse their recommendations,

1 and he wrote this letter to Secretary Cassells on
2 his own initiative congratulating the military for
3 the tremendous advances that have been made and
4 the lives that have been saved using tactical
5 combat casualty care.

6 Then lastly, this came from the Army
7 Medical Center and School. These are the people
8 who run their combat medic training and they say
9 tactical combat casualty care has revolutionized
10 the way that we manage casualties in the
11 prehospital tactical setting. So in the interest
12 of time and not running over Dr. Poland's time
13 limit here, I am not going to cover the new
14 changes that have just been recommended. They are
15 in our handouts. There are eight changes that
16 have been recommended at the April and July
17 meetings of the committee. It would be glad to
18 take any questions.

19 DR. POLAND: Thank you, Dr. Butler.
20 We've got 2 or 3 minutes for questions from any of
21 the board members.

22 DR. KAPLAN: The purpose of the board is

1 to approve, make suggestions. The action to be
2 taken by the board is to make suggestions, approve
3 the report. What exactly do you expect us --

4 DR. POLAND: Today is just an
5 informational briefing.

6 DR. KAPLAN: And ultimately will this
7 come back to the board for detailed discussion?

8 COLONEL GIBSON: Thank you, Dr. Kaplan.
9 I'll make sure I use your name when we're making
10 these discussions.

11 DR. KAPLAN: Thank you, Dr. Gibson.

12 COLONEL GIBSON: Let me explain just a
13 little bit about the organizational construct
14 here. Because this combat casualty care group has
15 civilian experts on it, for them to operate they
16 need to fall under a federal advisory committee.
17 Otherwise we run into issues with the Federal
18 Advisory Committee Act. The Department of Defense
19 and this board absolutely agree that trauma care
20 is a core competence of the board. You will
21 receive periodic updates from not only the TC3
22 group but the Subcommittee in Trauma and Injury

1 which has a broader scope to include prevention
2 issues. As those come forward, the board will
3 look at those guidelines, discuss them, deliberate
4 them in open session, and then they become
5 products of the board.

6 DR. KAPLAN: Just one follow-up. It
7 would appear that we're going to eventually run
8 into the issue of uniformity across services
9 again. That ultimately will come up for
10 discussion or not?

11 COLONEL GIBSON: I believe Frank can
12 address that right now. This group has
13 representatives from all services and it's a
14 consensus-building product. Not only that, but
15 they're writing the manual.

16 COLONEL BUTLER: Yes, sir. In concept,
17 all of the services agree. In execution there are
18 some differences. For example, I think special
19 ops is the only group that provides pulse
20 oximeters for their combat medics which is one of
21 our recommendations. Not everybody carries
22 battlefield antibiotics for the medics. I believe

1 the Marines do not. The Army does I think. In
2 some cases Colonel Paul Cordts has been working to
3 try to help get that used as appropriate in the
4 Army medical kits. So there are some differences
5 in implementation across the services.

6 DR. POLAND: Other questions?

7 MR. DUBOIS: Dr. Butler, does your group
8 address the composition of a corpsman or a medic's
9 kit that he takes to the field? I was an enlisted
10 man in Vietnam in 1968 and 1969 and when I also
11 got involved with Desert Storm 23 or 24 years
12 later, I found that the kit had not changed
13 appreciably at all. Are you working on this issue
14 today?

15 COLONEL BUTLER: We provide a list of
16 some basic things that we think should be in the
17 kit. We have no authority to provide oversight
18 for anybody's kit. For example, when we changed
19 the recommendations for hemostatic agents, the
20 U.S. Special Operations Command a month later
21 changed their kit for the medics to conform to
22 that. Colonel Cordts has been working feverishly

1 to try to make the appropriate changes to the Army
2 kits. So we do send all of the recommended items
3 that we discuss to the services for consideration
4 for adding to their kits. Again it's a service
5 decision and we just recommend.

6 MS. EMBREY: If I could comment on that
7 a little bit, medical logistics is an area that we
8 are putting a great deal of focus on right now in
9 terms of improving the entire supply chain
10 management from peacetime to wartime including
11 identifying the kit assemblage and identification.
12 A separate topic then, what a first responder does
13 and so the Tactical Combat Casualty Care Group has
14 been providing input on how the first responder
15 should be trained, what techniques, what tactics,
16 and what we can use to improve outcomes at the
17 first responder level.

18 We changed a lot of capability when we
19 moved forward our forward surgical teams in this
20 current war and that changed outcomes as well, but
21 if not for the work of Dr. Butler and his team, we
22 wouldn't have the positive outcomes that we have

1 now for the current conflict. So thank you for
2 your work, Frank, and I'm glad you have a forum
3 now to bring your recommendations that gives it
4 the weight that will get the attention that it
5 deserves so that we can address these through
6 policy rather than marketing.

7 COLONEL BUTLER: Yes, ma'am. Thank you.
8 Sir, another good example about your question, in
9 the most- recent guidelines that I went to Ms.
10 Embrey, Colonel Gibson, and Dr. Poland, the old
11 kits had 2-inch needles for treatment of tension
12 pneumothorax. There are about four papers that
13 have come out since the war started saying that
14 these needles are too short. There's one dramatic
15 paper that was published from AFIP that has a
16 picture of a person with a tension pneumothorax
17 and a 2-inch needle that's been inserted into his
18 chest wall that stops just short of the pleural
19 space and the person died. So we're now
20 recommending using the 8-centimeter 3-1/4-inch
21 needles and that's been pretty well supported in
22 the recent literature.

1 DR. POLAND: One more question.

2 DR. OXMAN: I have always been struck by
3 the differences in the applications by the
4 different services and some of those are justified
5 by the different missions and conditions but many
6 of them are not. It would seem to me that a
7 logical procedure would be if something that's
8 recommended by this group is not implemented then
9 there has to be or there should be a requirement
10 for an explanation as to why that happens rather
11 than just the passive situation where it doesn't
12 happen. Is there any way of doing that and is
13 that in the works?

14 COLONEL GIBSON: This is a federal
15 advisory committee. We advise, we recommend, we
16 scold, but we cannot mandate or order anything.

17 MS. EMBREY: That doesn't mean those who
18 hear it can't do something about it.

19 DR. POLAND: And I think it's important
20 to point out that it was a multiservice consensus
21 and evidence- driven process. Dr. Butler, thank
22 you very much.

1 COLONEL BUTLER: Thank you.

2 (Applause)

3 DR. POLAND: Our next speaker is Colonel
4 Michael Jaffee, the National Director of the
5 Defense and Veterans Brain Injury Center which is
6 the primary operational traumatic brain injury
7 component of the Defense Centers of Excellence.
8 He'll provide the board with an update on the
9 Traumatic Brain Injury Family Caregiver's Panel.
10 As you recall, this panel is congressionally
11 directed to develop curricula for family
12 caregivers of traumatic brain injury victims and
13 they've been hard at work. I might also add that
14 Ms. Shinseki who sits on our board is also a
15 member of that and perhaps afterwards, Pat, if you
16 have any comments that you want to make. His
17 presentation slides are found under Tab 3 of your
18 meeting binders and he'll provide us with an
19 update of the activities as well as the timeline
20 for when the curricula can be expected and we have
21 allotted 30 minutes for this.

22 LIEUTENANT COLONEL JAFFEE: Thank you

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 for the opportunity to provide this update and I
2 again wanted to recognize Ms. Barbara Cohoon who's
3 one of our very valued and active members who is
4 here joining us today as well.

5 DR. POLAND: I think you'll have to
6 speak louder or hold that up maybe toward you.

7 LIEUTENANT COLONEL JAFFEE: Again I
8 appreciate the opportunity to provide this
9 briefing, and I was recognizing again Ms. Barbara
10 Cohoon who is a very valued and active member of
11 the committee who has also joined us here today.

12 What I'm going to do during in this
13 brief period of time is quickly review the purpose
14 of why this committee was stood up. This is
15 different than some of the other committees that
16 are part of the Defense Health Board. It is
17 assigned a particular task or initiative as
18 opposed to providing policy recommendations or
19 guidance. The last time they had a formal meeting
20 was back in June. I'm going to report on the
21 outcomes from that meeting. At the same time the
22 panel convened an open town hall. I want tell you

1 about what happened with that and talk about the
2 timeline and the next steps on the project.

3 Again this whole initiative came about
4 from an congressional act from the National
5 Defense Authorizations Act in 2007 which mandated
6 a 15-member panel be convened to develop a
7 curriculum aimed at family caregivers of those who
8 suffer from traumatic brain injury who are members
9 or former members of the armed services.

10 DVBIC's role in this is to provide
11 programmatic and logistical support to the
12 committee to ensure the development of the
13 curricula according to the congressional mandate,
14 helping out with content accuracy, and helping to
15 provide a forum for implementation, evaluation,
16 and ongoing support for the Family Caregiver
17 Education Program.

18 The tasks of the panel for the last
19 meeting that we had was to conduct a review of the
20 literature on family care-giving for persons with
21 TBI in both military and civilian populations,
22 provide guidance to the writers who will be

1 synthesizing this information to develop a
2 consistent curricula for this education, and
3 recommend mechanisms for dissemination throughout
4 both the DOD and the Department of Veterans
5 Affairs.

6 From the June meeting, a couple of goals
7 were set out ahead of time. One was to have a
8 chairperson appointed of the committee, approve a
9 definition of family caregiver because that
10 definition helps drive and focus the further
11 efforts, and to develop an actual outline of the
12 content for the curriculum to give the writers
13 guidance as they press forward, establish work
14 plans for how this is going to be developed and
15 rolled out, and to hold a town hall meeting. From
16 the June meeting, we are proud that Ann Mosner
17 from the Mayo Clinic who runs the TBI Model
18 Systems Program there was selected as the
19 chairperson of this committee. The committee went
20 with the following definition for family
21 caregiver: any family member or support persons
22 relied upon by the service member or veteran with

1 traumatic brain injury who assumes primary
2 responsibility for ensuring the needed level of
3 care and overall well-being of that service member
4 or veteran.

5 The content was decided to be subdivided
6 into four different modules. Module one currently
7 is being referred to as a TBI 101 type of module
8 which would cover the basic information aimed at
9 patients and families, that being brain anatomy
10 and physiology, understanding TBI and the spectrum
11 of TBI. Module two focuses more on the symptoms
12 and their management that the families and their
13 patients would be following, focusing on the
14 physical, cognitive, and emotional sequeli and
15 guidance to their adaptation. Module three will
16 be focusing on the caregiver needs, resources, and
17 tools, things that could be of direct benefit to
18 the caregivers. An outline and draft has already
19 been prepared. And the fourth module was
20 something that was very important to the members.
21 They wanted some education for family caregivers
22 to understand the military and veterans' health

1 care system and benefits programs, challenging
2 tasks. I think we're hoping to provide some
3 guidance for families on that. We do have some
4 very good people who've taken the initiative to
5 try and synthesize a lot of that information
6 together from our colleagues with the VA as well
7 as the DOD.

8 There was discussion made about the
9 optimal ways for curriculum dissemination. It is
10 very much desired that this will be developed in a
11 multimedia format using web, print, CDs, other
12 appropriate technologies. We were fortunate to
13 have joining in that discussion representatives
14 from the DOD's only Center of Excellence for
15 Medical Multimedia. That center is currently
16 located on the grounds of the U.S. Air Force
17 Academy.

18 The topic of credentialing was broached
19 at this meeting. This was a question that had
20 come to the committee previous to the meeting and
21 there was a question whether the curriculum would
22 lead to credentialing of family providers. There

1 was a significant discussion on this issue, but
2 after consideration and response to these
3 questions, it was the consensus of the committee
4 that they felt that certification would imply that
5 the individual had obtained skills that were
6 validated and observed by a medical professional,
7 and going along that line, that particular
8 requirement was felt to be a bit beyond the scope
9 of the intent and goals of this curriculum. And
10 it was also pointed out that other organizations
11 that trained civilians had moved away from using
12 the word certification and instead providing a
13 certificate of course completion.

14 The town hall meeting was held on the
15 evening following the first day of the two-day
16 meeting. In addition to the broad representation
17 which was brought to the table by the committee
18 itself, the town hall was another public
19 opportunity to bring in more input. There was
20 wide dissemination and advertisement of this. It
21 was a web-streamed event. The record remained
22 open for comment following the town hall through

1 the end of June. The website is actually still
2 available for viewing and it will be so until
3 September 17.

4 Thirty people attended the town hall in
5 person. There were a number of other people who
6 joined in via the webcast. The people chose to
7 speak de novo testimony as opposed to responding.
8 Of note, there were four members of the audience
9 who were known survivors of TBI, and there was a
10 broad variety of representatives who were in
11 attendance at this meeting to include professional
12 organizations, patient advocacy organizations,
13 other federal agencies, even representation from
14 the congressional office.

15 The outcomes and some of the inputs that
16 were derived from this town hall, I'm just going
17 to bullet some of the more pertinent inputs and
18 points that were made. Family caregivers from
19 prior conflicts made it clear that they wanted an
20 opportunity to mentor today's family caregivers.
21 The desire was to make sure that in all the
22 curriculums that we develop, we emphasize a hope

1 of recovery, that hope should permeate throughout
2 the curriculum. One way of doing that and to
3 connect with people was felt to provide success
4 stories of service members from diverse
5 backgrounds who went through a varieties of
6 injuries and are doing well; providing information
7 on the course of recovery; again the point was
8 made to make sure that tools and information was
9 given to families and to be able to navigate the
10 health and benefit systems. TBI survivors wanted
11 more assistance in obtaining meaningful work. The
12 point was made that we want to be given
13 opportunities more than just being relegated to
14 the mailroom or being given lower-level types of
15 things which reminds to inform the panel as a
16 sidebar that since this panel let, the Department
17 of Labor has rolled out the America's Heroes at
18 Work program in cooperation and partnership with
19 the Defense and Veterans Brain Injury Center and
20 the Defense Centers of Excellence, a program aimed
21 at employers to integrate survivors of TBI and
22 psychological health conditions into meaningful

1 roles in the workforce.

2 Families also mentioned that the real
3 burnout factor that they can suffer and wanted
4 strategies to help prevent that. The point was
5 made that not everyone may have a family caregiver
6 and that needs to be recognized and acknowledged.
7 And the point was made that the term mild TBI
8 creates confusion for some family members who are
9 continuing to suffer sequeli because the term mild
10 may imply that it's really not very serious and
11 the families indicate that it does cause some
12 issues for them.

13 I want to conclude by reviewing the work
14 plan of how things are proceeding forward. In the
15 summer and fall and right now, our health
16 education writers, panel members, and staff are
17 writing and editing the four modules of the
18 curriculum. The panel will be reconvening on the
19 November 13 and 14. At that point the panel will
20 be approving the curriculum, selecting the
21 evaluation metrics, identifying sites to test it
22 out, and target the populations for the pilot

1 initiatives. It is planned that we can present
2 the entire curriculum and make that available to
3 the members of the Defense Health Board at the
4 December meeting. In February we want to begin
5 pilot testing of the curriculum at at least two
6 sites. In March we're going to review the
7 curriculum based on feedback from the pilot with
8 the goal of doing a much broader and wider
9 dissemination in April, doing a final evaluation
10 in May, and being able to do a final report in
11 August. I do want to remind the board of the
12 long-term plan when this happens. It is planned
13 that this subpanel of the Defense Health Board
14 would stand down and that the following,
15 monitoring, and revisions to this plan would then
16 fall to the TBI subcommittee of the Defense Health
17 Board. Again what we're driving for is the
18 benefits of this curricula would provide uniform
19 resources for caregivers in a consistent and
20 concise message, giving tools for coping, giving
21 some hope, while navigating life post-TBI and
22 navigating the DOD and VA systems. It is hoped

1 that the curriculum be informative and accurate,
2 provide management skills, not be overwhelming but
3 be user friends, teaching effective communication
4 skills, and based on real-life experience. I
5 thank you for your time.

6 DR. POLAND: I want thank you for your
7 work and emphasize the importance that this board
8 attaches to what has become a signature would of
9 this war and hence a signature opportunity for us
10 to really get this right and do this right. I
11 know there will be some questions. Colonel
12 Gibson, I'll ask him to start and then we'll move
13 around.

14 COLONEL GIBSON: Recently I've been
15 learning a lot more about caregivers, not only
16 what's going on within the Department of Defense,
17 but within the other agencies. I was hoping to
18 get some comment, some opinion from you and Dr.
19 Cohoon with respect to your feelings about this
20 effort to develop a curriculum for TBI family
21 caregivers and how that might transcend the issue
22 of caregivers in general for other not only

1 traumatic type wound care but other caregivers
2 across the board including cancer victims and
3 heart, et cetera. Do you have any comment?

4 LIEUTENANT COLONEL JAFFEE: One of the I
5 think valuable aspects of the process that's been
6 followed is the coming together of a variety of
7 individuals, both members of the panel itself and
8 bringing in the feedback. So we're really seeing
9 I think a convergence and collaboration between
10 federal agencies, between the VA, between the DOD,
11 between patient advocacy, between professional
12 groups. So I'm hoping that that might serve as a
13 model and a springboard. And there are certain
14 commonalities which are emerging such as
15 navigating the benefit system and issues of
16 respite and the need for burnout and those types
17 of resources. So I do think that there are a lot
18 of commonalities that could be used as a
19 springboard for other types of family caregiver
20 needs and initiatives as well as the setting I
21 think of a very positive precedent of trying to
22 bring all the stakeholders together to come up

1 with a combined collaborative effort. So
2 hopefully I think the committee will be very proud
3 to think or hope that this could help inspire
4 future efforts and initiatives.

5 DR. BLAZER: Just a couple of comments.
6 One is among the groups of caregivers for
7 different disorders, probably one of the
8 best-organized and most effective is the group for
9 Alzheimer's disease which is actually very close
10 to the kind of difficulties I think that people
11 will be working with the traumatic brain injuries.
12 My second comment, I realize how difficult it is
13 to put together modules, but I cannot emphasize
14 enough how important I think getting that module
15 in as good a position as possible is.

16 DR. WILENSKY: Thank you. You mentioned
17 that part of the guidance will be navigating
18 through the DOD and the VA. I wanted to just
19 follow that up a little bit by asking whether
20 there's been commitment by both DOD and VA to use
21 the same curricula once you have it developed.
22 It's one thing to help get through both sides, but

1 you really want to have the individuals in both
2 agencies using the same curricula. At least that
3 would be a much stronger way to have uniformity.

4 LIEUTENANT COLONEL JAFFEE: I agree. We
5 are fortunate to have some of the VA leaders in
6 this who are participating as members of the
7 panel. They have expressed that commitment. One
8 of the values of the Defense and Veterans Brain
9 Injury Center although I'm a member of the DOD and
10 I'm wearing the uniform, the V stands for veterans
11 and so the DVBIC is a collaboration between the VA
12 and the DOD where we do work a lot together to
13 come up with common aspects and resources. So a
14 lot of the dissemination is actually going to be
15 through the VA facilities and the polytrauma
16 centers at the DVBIC. So I think that we are
17 seeing that collaboration and it's my
18 understanding and belief that the VA will be using
19 the same curriculum that they helped develop.

20 DR. POLAND: A couple of questions. One
21 is in that module four, and I'm sure you've
22 thought of it, but I think it's imperative that we

1 develop some way that there's a one-stop shop or
2 person or contact for family caregivers and not
3 expend their time and energy in the myriad of
4 people that they get shuffled to, and I hope that
5 will be front and center of that module four.

6 LIEUTENANT COLONEL JAFFEE: I think
7 that's the goal and the vision. There are efforts
8 underway. Perhaps some of my other DOD colleagues
9 can follow-up on this comment, but my
10 understanding is that a lot of those efforts are
11 already underway including a website which is
12 being tested which his geared toward family
13 members to help navigate these benefits which
14 would be incorporated into this curriculum. I
15 think a lot of people share that vision.

16 DR. POLAND: Second, I have a couple of
17 suggestions. I agree with this issue of
18 designating it as "mild" rather than saying it's a
19 traumatic brain injury, stage one through three or
20 something like that, and I'm glad to see that
21 emphasis.

22 The last suggestion I have is in your

1 work plan flow, and I know there are a number of
2 expert people on the committee, but I wonder in
3 prior to pilot testing if there might be the
4 opportunity to send that curriculum to some
5 external content experts outside of the
6 subcommittee and get their comments and read on
7 that and then pilot it and then move forward from
8 there.

9 LIEUTENANT COLONEL JAFFEE: I'm sure
10 that could be done especially with the contacts
11 and current components of the committee who have
12 linkages to academia and other experts. That
13 would probably be a worthwhile endeavor.

14 DR. POLAND: I'm going to try to get
15 around Mike and then I think there's another
16 comment over here.

17 DR. PARKINSON: Michael, excellent
18 presentation and the group is to be commended. I
19 have to admit personally I begin to get urticaria
20 when I see the word curriculum versus words like
21 competencies, skill sets. My response on this is
22 that next-generation learning as you all know is

1 really all about how do I personalize and acquire
2 the competencies to be able to better adapt and to
3 help. As you get into the dissemination mode,
4 please think strongly about getting away from
5 traditional PowerPoint slide flat content into
6 simulations, into gradual acquisition of skills,
7 into social networking which is the ability to
8 link people online to similar family needs either
9 electronically or virtually, technologies that
10 exist today, that really are important if this
11 thing is to be successful. We want to create a
12 vibrant, connected community of DOD family members
13 and caregivers who can on a moment's notice turn
14 for support, for competence acquisition, and for
15 information. Yes, there's part of that, there's
16 curriculum about the physiology of TBI or mild
17 TBI. It is a minor part. So as we go through
18 this, it's very important as we talk about these
19 things that we get right into the practical skill
20 sets, how do we role model, how do we practice,
21 how do we improve those using advanced
22 technologies and competence acquisition which is

1 what I think our folks are looking for. So it's
2 in there, but I just want to make sure that at the
3 end of the day I think that's what our family
4 members want.

5 DR. POLAND: Ms. Shinseki?

6 MS. SHINSEKI: Just a very small
7 comment. I would like to also recommend that in
8 the dissemination of information and in the
9 development of the coursework that we address the
10 needs of the children who are also part of the
11 family, and they are definitely affected by the
12 caregiving and by the intense stress that a family
13 undergoes. Thank you.

14 DR. POLAND: Dr. Halperin?

15 DR. COHOON: Patty, you and I talked and
16 actually the children piece is going to be
17 expanded. We've asked for that. Then as far as
18 how to maybe have their own piece as far as
19 getting information, there is a section already in
20 there as far as to be cognizant of the impact on
21 this as far as children, and I also asked for that
22 to be expanded and have been told that will be

1 expanded.

2 DR. HALPERIN: I noticed that one of the
3 slides is that not everyone has a family
4 caregiver. With compliments to all the work and I
5 hope and I'm sure it will be successful, there is
6 at the margin the prospect of failure, that is, no
7 family caregiver. The person and the family is
8 unable to navigate the VA/DOC benefit system.
9 Family can't absorb or have resources to take care
10 of the member and the person becomes homeless, et
11 cetera. Is there a crisis module when things are
12 just falling apart that you're planning?

13 DR. COHOON: Yes, that is also included
14 in that, and then we've also asked for it to be
15 expanded further with those particular pieces.
16 There is a section that talks about planning ahead
17 and making sure that you've put some things as far
18 as what may happen in the future. And there's
19 also a section on opting out as far as what your
20 plans are there if you find that this is not
21 working for you and what your resources. Then
22 there's also a section there as far as in between

1 when you're experiencing stress or compassion
2 fatigue, what it looks like, what you can do to
3 help yourself with resources that are there.

4 DR. POLAND: Dr. James and then Dr.
5 Oxman.

6 DR. JAMES: The program looks fantastic
7 but over time a lot of this is going to evolve
8 into the civilian sector of medical care, both the
9 patient, the family especially, and children. How
10 do we get these efforts better integrated into the
11 greater civilian sector so there isn't a
12 dichotomous now you have it, now you don't?

13 LIEUTENANT COLONEL JAFFEE: I think that
14 speaks to a lot of the collaboration between the
15 DOD and some of the civilian agencies. That very
16 topic has been discussed between DDVIC and the CDC
17 who helps provide educational materials and fact
18 sheets for civilian providers and families, and we
19 have been collaborating with them and we share
20 with one another in developing products. So I
21 imagine that we would encourage them to use this
22 product as they saw fit. Again, as you also

1 pointed out or what I was hearing is things might
2 change and advice may change so there needs to be
3 a plan for periodic monitoring and evaluation and
4 updating as our understanding further evolves as
5 well.

6 If I could quickly respond to Dr.
7 Parkinson, the idea of competencies was very much
8 discussed and I think informs a lot of
9 development. Our reports that we make to Congress
10 and to the board use the word curricula because
11 that's how the law was passed down to us. And the
12 multimedia aspect I think is very important. We
13 were very pleased to learn about a lot of the
14 options for interactivity through the Center of
15 Excellent for Medical Multimedia and I think the
16 vision is to make it as interactive and user
17 friendly as possible using all those modalities.

18 DR. POLAND: Dr. Oxman?

19 DR. OXMAN: Colonel Jaffee, are you
20 approaching in any way the problem of the legal
21 restrictions on the VA providing any care and
22 resources to anybody but the veteran?

1 LIEUTENANT COLONEL JAFFEE: No, because
2 we're developing a curriculum which could be used
3 for family members of anyone. And again, if we
4 make it public domain and anyone else wanted to
5 use that curriculum, we would allow them to do so.

6 DR. POLAND: Let me ask Ms. Embrey to
7 make a comment about the transcendent aspect that
8 goes above and beyond TBI that I think will be
9 important to board members.

10 MS. EMBREY: Mike, thank you very much
11 for your comments. This briefing is focused on
12 what the DVBIC and the Defense Center of
13 Excellence together with the VA are developing for
14 the families. Inside the Department of Defense
15 there is an elaborate management initiative
16 addressing multiple requirements for our wounded,
17 ill, and injured service members and their
18 families. What I wanted to say is that when it
19 comes to family support, children, adults,
20 caregivers and so forth, there is a series of
21 specific initiatives that have been undertaken in
22 terms of identifying benefit packages associated

1 with different tiers of injuries, the most severe
2 to the most mild and everything in between. Right
3 now there is a significant effort to create
4 resource centers in each service tied together
5 into a single resource center that allows anybody
6 whether you're in or out of the Department of
7 Defense, Veterans Affairs or any other place to
8 tap into that resource center to get information
9 that you need.

10 As I understand it, the department is
11 planning to roll out that center beginning next
12 month in October. Monday. We'll see. I'm not
13 going to put them on the spot, but it's going to
14 be real soon now. But what I would say to you is
15 that this whole idea of helping people navigate
16 the stovepipes of knowledge between and among the
17 military departments as well as in Veterans
18 Affairs, it is daunting for a family that is also
19 dealing with physical injuries and mental
20 injuries. So this resource center has been set up
21 to do this, and what Mike is talking about here is
22 that which is specific to TBI. As you all know,

1 TBI is something that affects people with other
2 injuries as well, so they're not just coping with
3 traumatic brain injury problems, there may be
4 other physical issues. So although this is
5 focused on TBI, there is a larger family support
6 program being designed and implemented together
7 with the VA. I wanted to make sure you were aware
8 of that, number one, and number two, I would like
9 to offer to you at your next meeting a broad
10 briefing from the senior oversight committee
11 management who can characterize how the DOD and
12 the VA have been collaborating on a series of
13 specific eight broad areas of improvement in both
14 agencies to handle transition, to handle care and
15 coordination, to handle traumatic brain injury and
16 mental-health challenges, to handle benefits and
17 pay and personnel problem issues. So there are a
18 number of initiatives that are being focused on
19 over the last 2 years at the very senior levels of
20 both departments, of the VA and DOD. So I wanted
21 to make sure that you knew that that was going on
22 and that we arranged to have someone come and

1 brief you on this because this is just a TBI,
2 mental-health, DVBIC initiative which is
3 responsive to congressional direction and the
4 panel that was formed to get family support and
5 input on how we could improve that specific area,
6 but it's much bigger, much bigger.

7 DR. POLAND: Colonel Jaffee, thank you.
8 Just to reiterate what I heard in terms of
9 concerns and suggestions from the board is that
10 there be an informed and passionate advocate
11 contact in that module for the change in
12 terminology away from mild, review of the
13 curriculum by outside subject-matter experts, the
14 inclusion of children in the curriculum, and I
15 think very important, Dr. Parkinson's comments
16 about moving beyond just curriculum to
17 competencies, and we'll look for those elements
18 then when you come back to us in December. Thank
19 you very much.

20 Let me also recognize and introduce
21 Secretary West. He just joined a briefing or so
22 back. Secretary West, if you could just introduce

1 yourself and give us a brief background about
2 yourself for the board. Did anybody else come in
3 who wasn't part of the initial introductions?

4 SECRETARY WEST: Thank you, Mister
5 Chairman. I'm Togo West. I think what I bring to
6 this is that at one time I was a soldier and at
7 another time I reported to soldiers as Secretary
8 of the Army and then later as Secretary of
9 Veterans Affairs. Since you gave me this
10 opportunity to introduce myself, two comments.
11 I've heard you make that point before about being
12 careful when we deal with VA's role in matters,
13 that they not be hamstrung by a rather ancient
14 legislative prohibition. But as you know as well
15 as I do, those words tend to have a chilling
16 effect, that VA can only provide assistance by law
17 to veterans when in fact over the history of the
18 program we've provided assistance to lots of
19 people other than veterans, veterans' families,
20 veterans' benefits. The real point you're making
21 is when we tailor programs like this to make sure
22 that we make it possible for VA to do everything

1 it needs to do to make it successful, and I don't
2 think that's a problem.

3 Secondly, I'm very glad that the fact
4 that many of these veterans, these service members
5 do not have a family caregiver, because the fact
6 is, and I think the response made it clear, that's
7 not acceptable. Even as we design a program, to
8 note that someone may not fit our definition is
9 not to allow us to avoid the obligation to make
10 sure that there's a provision made whether it's
11 training for how to find one. I took your point,
12 Ellen, to be that that's part of the larger VA/DOD
13 program. Thank you for the opportunity.

14 DR. POLAND: Thank you. We'll take now
15 a brief break. Set your watches for 10:15. Dr.
16 Kelly, I think you'll be up first and ready to go
17 by then. Thank you.

18 (Recess)

19 DR. POLAND: Our next speaker is Dr. Jim
20 Kelly, professor of neurosurgery and physical
21 medicine and rehabilitation at the University of
22 Colorado School of Medicine, Associate Director of

1 the Colorado Area Health Education Center System,
2 and Chairman of the Traumatic Brain Injury
3 External Advisory Subcommittee. He'll provide an
4 update on the activities of this subcommittee and
5 the slides for his briefing are also found under
6 Tab 3. I want to point out the fact that the
7 board has two subcommittees working on TBI issues
8 which relates to the importance and concern that
9 both the DOD and the board feel about this
10 subject. Dr. Kelly, I think we have also allotted
11 30 minutes for this.

12 DR. KELLY: Thank you, Dr. Poland. Ms.
13 Embrey, Mr. West, board members, thank you for
14 allowing me this opportunity. The slides that you
15 have have been minimally modified. As you'll see,
16 I couldn't send some of the pictures that I'll
17 show you. They couldn't be sent by electronic
18 email, or at least maybe I couldn't figure out how
19 to do that.

20 What I would like to do first is show
21 you the list of the wonderful subcommittee members
22 that we have and explain just in a minute who they

1 are, where they are. Dr. Ross Bullock is at now
2 the University of Miami, had been at the Medical
3 College of Virginia, Virginia Commonwealth
4 University. Many of you may remember his career
5 there. Dr. Guy Clifton, University of Texas,
6 David Hovda, UCLA, Grant Iverson, University of
7 British Columbia. He is an American but he's
8 working up there in Canada now. Gene Langlois who
9 is at the CDC. James Lockey at the University of
10 Cincinnati. You don't have on your page I think
11 Michael McCrea, a neuropsychologist at the Medical
12 College of Wisconsin. Here with us today is Dr.
13 Joseph Parisi from Mayo Rochester. Bill Perry,
14 the past President of the National Academy of
15 Neuropsychology and at UCSD. Dr. Alan Ropper at
16 Harvard. Dr. William Snider at the University of
17 North Carolina, Chapel Hill. And Gail Whiteneck
18 who's near me out there in Colorado at Craig
19 Rehabilitation Hospital. I also wanted to mention
20 here on this screen the passing of a wonderful
21 mentor of mine and perhaps many of us in this
22 room, Professor Brian Jennett, a neurosurgeon from

1 the University of Glasgow. Professor Jennett died
2 earlier this year as you can see after a very long
3 and storied career. This wonderful man took me on
4 a tour of the University of Glasgow and the Royal
5 College of Physicians and Surgeons when I visited
6 just a few years ago. This is him standing in
7 front of the residence -- the professors who are
8 also chairmen at the universities in Europe as you
9 may know where they were offered housing in this
10 magnificent facility. He was eager to tell me
11 about the University of Glasgow which was founded
12 many, many years before Columbus discovered
13 America. He was very proud of his institution. I
14 should also mention that Professor Jennett and I
15 and others co-authored a paper on a term minimally
16 conscious state back in 2002. This was a
17 wonderful opportunity for me. Those of you who
18 studied medicine and trauma certainly know the
19 Glasgow coma scale, the Glasgow outcome scale, and
20 the term which he coined persistent vegetative
21 state all of which were among his many
22 contributions over this long career. It was

1 wonderful and we mourn his passing. Professor
2 Jennett in his last peer-reviewed publication that
3 I can find said, "It is important not to assume
4 that because a patient is classified as only
5 mildly injured, he has not sustained any brain
6 damage," to the point that was made earlier
7 perhaps.

8 The problem that you know we have
9 presently is largely happening in the geography of
10 Iraq we've come to know so well, the OIF current
11 phase with many explosions, and this is just one
12 picture that many of you in the room certainly are
13 familiar with with the IED or rocket- propelled
14 grenades or other explosive devices that are
15 injuring our military personnel. I just want to
16 make one mention of blast injury. This is a slide
17 prepared by Dr. Debbie Warden and her colleagues
18 with Mike Jaffee at DVBIC. The blast injury as
19 you may know, traumatic brain injury, both of them
20 said to be the signature injuries, there's direct
21 exposure to overpressurization wave roughly at the
22 speed of sound in the air. There's a secondary

1 impact from flying debris. There's a tertiary
2 injury in terms of the actual movement of the
3 person's body up against something often. And
4 then there can be burn and inhalation of gases as
5 all components of this injury. Mild traumatic
6 brain injury is certainly the common denominator,
7 if you will, of that. And I also would like to
8 point out the importance of addressing the concern
9 which another committee and other groups are
10 dealing with of posttraumatic stress disorder.
11 Here we have near Balad in a PTSD or acute stress
12 disorder type counseling room in Iraq a rocket
13 that actually landed and did not explode in the
14 facility where individuals were being cared for
15 for stress disorder. So the fear and the issues
16 of distress that occur amongst our military as
17 well as bodily injury certainly overlap and need
18 to be addressed.

19 The TBI External Advisory Subcommittee
20 first met for its organizational meeting on
21 Rockville, Maryland, in April of this year. We
22 had an overview of your operations as a board, an

1 overview of the Defense Centers of Excellence.
2 There were administrative and government employee
3 business concerns and the ethics briefing that
4 you're all familiar with. Then the idea of us
5 getting together as a group for the first time and
6 brainstorming as to what the issues were that we
7 would need to address, and I'll go into that
8 shortly. Then there was the business of electing
9 chairmen which ended up naming me.

10 The next meeting was on June 10 at
11 Walter Reed Army Medical Center. I asked for it
12 to be specifically there so that we could get a
13 tour of the facility knowing that as it exists now
14 it will be decommissioned before long and I wanted
15 members of the subcommittee to be familiar with it
16 before then. I wanted an overview from DVBIC
17 which was nicely provided. There was an overview
18 of the pre- and postdeployment health assessments
19 which we can go into in more detail if you like.
20 And then we heard about a head- to-head comparison
21 of neuropsychological tests. There are
22 computer-based neuropsychological assessments

1 available in this country and there's a study up
2 and running now comparing one against the other.

3 We also had a discussion about the
4 congressional directed Medical Research Program.
5 We had a presentation by a panel of military
6 personnel involved with TBI clinical care in
7 theater, in intermediate stages, and in
8 rehabilitation programs here in the U.S. Then one
9 action item that was decided on at that particular
10 time was that one member of the TBI subcommittee
11 will attend each of these meetings in the future
12 to report to you and to answer questions.

13 Things that have happened in the
14 meantime that I and others have engaged in as
15 members of this subcommittee, we attended the DCOE
16 summit. I believe it was the second such summit
17 in San Antonio in June of this year. WETA here in
18 Arlington taped a video broadcast which I'm told
19 is now available on the web but I haven't seen it
20 on this very issue of traumatic brain injury. I
21 and others participated in that. The United
22 States Army had a grant to develop TBI education

1 modules for health professionals. Several members
2 of the subcommittee have been engaging in that
3 process either by remote by telephone or in person
4 here in the Washington area in the last few
5 months. And one other meeting that I attended was
6 for the National Area Health Education Center
7 organization annual meeting which was held in
8 Denver this year. We learned recently that the VA
9 and HRSA, the federal agency, have agreed with the
10 memorandum of understanding to share educational
11 modules across areas of health concern, traumatic
12 brain injury being the one that actually pushed
13 this forward, so that now we have a listing of all
14 of what are VA educational modules and traumatic
15 brain injury that can then be routed through a
16 different federal agency which is an umbrella over
17 Health Education Centers nationwide. If you're
18 not familiar with that system, I should mention
19 Area Health Education Centers came into existence
20 due a federal law back in 1972 and 48 states
21 currently have these nonprofit bridges from
22 communities to academic health centers in their

1 states. So what we have is a route, a conduit,
2 for education on traumatic brain injury from
3 federal agencies, in this case the VA, to the
4 AHECs nationwide where I'm told the majority of
5 our veterans still obtain health care, it's in the
6 vicinity of 70 percent of our veterans I'm told,
7 get their health care outside of a VA and largely
8 now in the current conflict in rural America. And
9 those AHECs were specifically federally designed
10 to go to small-town America, rural America, and in
11 underserved areas in order to increase the level
12 of sophistication and health education not just
13 for physicians but all health providers. So we
14 have an opportunity here to link to the AHECs
15 nationwide to get these education modules and
16 other curricula as they were called earlier out to
17 health professionals nationwide.

18 There has also been a Psychological
19 Health and TBI Standardization Committee. There
20 have been to my knowledge two meetings of this
21 group looking at the very issues of definition,
22 how do you define mild TBI and so forth. And then

1 the DVBIC sponsored an update consensus conference
2 on the clinical practice guideline for mild
3 traumatic brain injury which has been used in Iraq
4 and Afghanistan since 2006 when it was first
5 created and rolled out.

6 Future topics that the subcommittee
7 intends to address would be to advise regarding
8 traumatic brain injury research priorities for any
9 future initiatives, request information regarding
10 the financial liability for the diagnosis of
11 traumatic brain injury and its care. Those of on
12 the subcommittee who work in the private sector
13 are acutely aware of the costs associated with
14 making this diagnosis and the often long-term care
15 necessary and we are curious about how that works
16 in the military systems; open discussions
17 regarding acute stress disorder and PTSD and in
18 that vein we will include that as part of our
19 upcoming meeting. You've already heard from
20 Colonel Charles Hogue I believe it was the very
21 last gathering of the board, and so he will be
22 offering a presentation on his research to us at

1 the next meeting.

2 We want to inquire most as to the use of
3 electronic medical records especially in the
4 field. We understand that that hasn't been
5 working as well as it could and we would like to
6 understand better how it might work better and
7 what observations and contributions our
8 subcommittee can make. There is also additional
9 opportunity now to update and standardize the use
10 of MACE, the military acute concussion evaluation.
11 I should mention that within that is a mental
12 status test which we have found in the sports
13 community quite useful in detecting the cognitive
14 effects of concussion. It has been used for many
15 years in the military. It is actually a component
16 of the MACE, that mental status test is, and so
17 it's now being validated in the acute military
18 setting in theater.

19 Our next meeting will be very soon.
20 Here I've asked for it to occur at the National
21 Naval Medical Center so once again our
22 subcommittee gets a feel for what happens at that

1 level of care. We will have the presentation on
2 PTSD research by Colonel Hogue. We will discuss
3 the deployment-related health assessments and TBI
4 screening both at the military and VA levels. We
5 also intend to take on a little bit more detailed
6 discussion of the computerized neuropsychological
7 testing. I can share with you some of my concerns
8 if anybody has questions about the sensitivity and
9 lack of specificity of these kinds of tests and
10 how they can be misunderstood in the settings in
11 which they're being used currently. We also
12 intend to look into the joint theater trauma
13 system in more detail and understand that better
14 with the identification of mild TBI and the care
15 that's provided in theater. We need to hear more
16 about psychological health and TBI research in
17 combination. And we have to have a better
18 understanding of the organizational structure of
19 related military TBI programs of which there are
20 quite a few as we look around.

21 That's my contact information. You have
22 that in your handout under the subcommittee

1 listing. But at this point let me end my formal
2 presentation and ask for questions.

3 DR. POLAND: Thank you very much. We
4 have an opportunity for questions. Dr. Lednar?

5 DR. LEDNAR: Dr. Kelly, first thanks for
6 the leadership that you're bringing to this issue
7 and the subcommittee. Our legacy in medicine has
8 in my view unfortunately created this divide in
9 our approach to patients, separating their mental
10 health and psychological needs across a very wide
11 chasm from more medical/surgical approaches.
12 Clearly we want to provide good care to the
13 patient, to the soldier, for example. Do you have
14 any impression so far in the work of our committee
15 about how DOD is doing in terms of bringing
16 together both the mental health and the neurologic
17 perspectives into a single well- coordinated care
18 plan?

19 DR. KELLY: I think that first of all
20 the standing up of the DCOE for psychological
21 health and TBI is a big step in that direction.
22 There is an acknowledgement specially by General

1 Sutton that the brain is the organ of the mind and
2 to separate the two is failed thinking, frankly.
3 So this idea of Descartes years ago, we need to
4 move beyond that. We need to understand that mind
5 and brain are really the same. When injured or
6 when affected in any significant and/or severe
7 way, we need to understand the pathopsychology
8 better, we need to understand the treatments
9 better. I can tell you as a clinician taking care
10 of concussion patients many of whom have in
11 certain settings stress disorder or PTSD, the
12 treatments are essentially the same. So if we're
13 treating the individual we have to take into
14 consideration the effect on mentation and behavior
15 and emotion. I think that there's a good
16 understanding at least amongst the members of the
17 subcommittee with regard to that particular
18 concern and I see the Department of Defense
19 specifically and DVBIC's role for many years
20 helping explain that to lots of other people. I
21 understand the concerns and I see how there is
22 still some distinction being made, but I think the

1 closer we get to each other and understand each
2 other's perspectives for mental health and
3 neurology specifically the better we'll be able to
4 handle this situation and care for those
5 individuals.

6 DR. LEDNAR: Just one follow-on, and
7 that is there may be some important observations
8 your subcommittee has that will be very important
9 to feed into the Health- Care Delivery
10 Subcommittee discussions because we want to
11 organize the delivery of care to provide quality
12 care as you're seeing it.

13 DR. KELLY: Yes. Thank you.

14 COLONEL GIBSON: Let me add one quick
15 caveat to that. The Traumatic Brain Injury
16 Subcommittee, the Psychological Health
17 Subcommittee, and the Amputee Patient Care panel
18 have all conceptually agreed to having combined
19 meetings as you can well imagine. We've just
20 discussed the two issues in general, but with
21 respect to amputees, their risk for TBI is
22 considerably higher than the average. So meeting

1 together and adding our trauma folks as well is
2 doable in concept. It's just the matter of
3 getting everybody together in the same place at
4 the same time.

5 DR. KAPLAN: My premise may be wrong,
6 but one gets the impression that perhaps the
7 action on the ground particularly in Iraq is not
8 as intense as it was at the time when these issues
9 were initially brought before the Defense Health
10 Board at this point. If that premise is correct,
11 does this offer an "advantage" in terms of field
12 testing? Should this offer of better advantage
13 for field testing and discussion of the various
14 programs that you've outlined for us? If my
15 premise is wrong, I apologize.

16 DR. KELLY: If I understand your
17 question, it's have the incidence of traumatic
18 brain injury declined in recent times and does
19 that offer an opportunity for investigation that
20 we didn't have before?

21 DR. KAPLAN: Yes.

22 DR. KELLY: I'll defer to Colonel

1 Jaffee. Colonel Jaffee, is it true that the
2 incidents have really declined? I'm not sure that
3 that's in fact the case.

4 DR. KAPLAN: That was just a premise. I
5 don't know whether it's even true or not, but if
6 it is, I'd be interested in your thoughts about
7 it.

8 LIEUTENANT COLONEL JAFFEE: When we hear
9 about things that are happening in theater and the
10 decreased violence, I think the numbers that are
11 most affected are the moderate to severe injuries.
12 One of the biggest challenges faced by the DOD is
13 the largest percentage of injuries which would be
14 classified as concussion or mild TBI and those
15 numbers seem to be fairly across the board when
16 you look at the incidents or percentages of that.
17 That's really where a lot of the policy challenges
18 that we're faced with lie and that's where we're
19 hoping a lot of the advice and counsel from the
20 Defense Health Board will help us. So as far as
21 managing those concussions, I think that is very
22 much still a challenge for the DOD even if the

1 more severe injuries happen to be waning at a
2 particular point in time.

3 DR. KELLY: If I could also just add to
4 that. My understanding unless it's changed, about
5 half of all traumatic brain injuries seen
6 currently in the active military population is
7 related to a blast and half is everything else.
8 It's motor-vehicle collisions, falls, and assaults
9 and so forth, very little in the way of
10 penetrating injury because of the protective
11 devices, but some of that as well. So when I see
12 clinically blast survivors, I am startled by the
13 numbers of exposures that they've had, upwards of
14 100 for certain individuals who have been there
15 for a 15-month deployment as they protect these
16 convoys back and forth in parts of Iraq. They
17 often are very remote but sometimes right there in
18 the vehicle they're destroyed and they get through
19 that after the small-arms fire and go back the
20 next day in a different vehicle on the exact same
21 road doing the exact same thing. So you can
22 imagine the combination of anxiety state and the

1 effect that has on brain function plus the
2 biomechanical factors some of which we really are
3 just now coming to understand.

4 And I think as Mike Jaffee is
5 suggesting, as far as we can see things are pretty
6 stable in terms of numbers, and of course because
7 of the complexities involved in trying to do
8 research in that setting and validate instruments,
9 you can fully appreciate how difficult that is and
10 I'm not sure that even reducing the incidents
11 really addresses that.

12 DR. POLAND: Dr. Blazer?

13 DR. BLAZER: Dr. Kelly, thanks for your
14 presentation and for your attention to this
15 important category of patients. Proceeding from
16 the conversation about a milder form of TBI and
17 just turning attention for a moment to the more
18 severe categories, I would just like to mention to
19 the board that in the patients who have suffered
20 catastrophic neurologic problems, and you alluded
21 to the persistent vegetative state just in
22 introducing your talk, I think it would be

1 interesting for the Ethics Subcommittee to be
2 involved in any conversations about the moral
3 status of a person who is given that diagnosis,
4 and that's just a comment. Thank you.

5 DR. KELLY: I'd be happy to do that.
6 Thank you for that. I should point out, by the
7 way, that the term minimally conscious state which
8 Professor Jennett and I authored and coined that
9 term in meetings in Aspen years ago, there is a
10 center that is affiliated with DVBIC is my
11 understanding. Is it up yet, Mike, or is it
12 coming up, in Pittsburgh, not Pittsburgh, but in
13 Pennsylvania, intended to be treating those
14 individuals who have severe traumatic brain injury
15 and are in a minimally conscious state?

16 LIEUTENANT COLONEL JAFFEE: Right.
17 There was an international panel that was put
18 together of both national and international
19 experts on optimal treatment for the minimally
20 conscious population. There was consideration for
21 us establishing a center for that population.
22 With the back and forth that has happened, those

1 recommendations are being passed along to the VA
2 to bolster the technical aspects of their current
3 emerging consciousness programs to the four
4 polytrauma centers and what is going to be built
5 or what has been authorized is a high-tech
6 assisted-living program for those individuals who
7 still need full-time nursing care utilizing the
8 best in assistive technology. So emerging
9 consciousness is going to be a partnership with
10 the VA and we're going to do what we can with this
11 combined initiative toward high-tech assisted
12 living.

13 DR. POLAND: Dr. Parisi?

14 DR. PARISI: As a neuropathologist, I
15 have more than a passing in this topic and I have
16 to applaud your efforts, Dr. Kelly. I think
17 you're doing a wonderful job with this
18 subcommittee. I do want to emphasize though that
19 this is a very unique injury and it provides a
20 unique opportunity to advance our basic
21 understanding of the pathophysiology and I'm
22 delighted to hear that there are studies that are

1 underway at AFIP to try to define at least the
2 pathologic features of these disorders.

3 DR. KELLY: Thanks, Dr. Parisi. We'll
4 look forward to that.

5 DR. POLAND: Thank you very much.

6 DR. KELLY: Dr. Poland, thank you.

7 DR. POLAND: I do want to acknowledge
8 that a couple of board members, Dr. Pierce
9 Garnder, Pierce if you could raise your hand,
10 joined us who's an associate dean at Stonybrook
11 and also still involved with the Fogerty Center at
12 NIH. And Dr. Joe Kelley who is the Deputy
13 Assistant Secretary for Clinical and Program
14 Policy, OSD Health affairs. Thank you, gentlemen,
15 for being able to join us. Our next speaker is
16 Dr. Mike Parkinson who's President of the American
17 College of Preventive Medicine, a member of the
18 core board, and Chairman of the Health Care
19 Delivery Subcommittee. Several and multiple new
20 members have been appointed to the Health Care
21 Delivery Subcommittee and they have a number of
22 issues to discuss and deliberate, and they will

1 facilitate the discussions regarding health care
2 best practices. Dr. Parkinson is going to provide
3 an update on the subcommittee and best practices
4 in the Health Care External Advisory Group. I
5 might just add, it's probably obvious, but
6 undergirding or perhaps superseding everything
7 this board talks about is the ability of DOD to
8 efficiently and in a cost-effect way deliver
9 quality health care. So this is a primo issue for
10 the board. Mike?

11 DR. PARKINSON: Thank you, Dr. Poland,
12 and good morning everyone. On a little bit of a
13 lighter note, first, I'm not going to do any death
14 by PowerPoint. You don't have any slides in your
15 presentation under Tab 4. This is a developmental
16 informational brief. We want your feedback at the
17 high-level concepts of what we're developing here
18 as a roadmap going forward.

19 On a personal note, let me just give you
20 reflections over the last 2 weeks. I've had the
21 privilege to address both major parties in the
22 silly season, in Denver and in St. Paul. The most

1 recent engagement was yesterday when I addressed
2 the Ohio delegation and was informed that the
3 starting time at 8:30 had been pushed back to
4 about 7:15 because we had a special speaker, so I
5 said fine. I just have a 10-minute blurb on
6 health and health care reform in general on behalf
7 of this organization called the Partnership to
8 Fight Chronic Disease. I will tell you about that
9 in a minute. The speaker turned out to be Karl
10 Rove. Karl Rove gives one hell a stem-winding
11 speech particularly at things like the Republican
12 National Convention. After he spoke very
13 eloquently and very engaged to an audience that in
14 that particular setting very passionate about what
15 he had to say to learn his message, I was supposed
16 to get up and give a talk on health care. I said
17 what in the world? I got up and I said, ladies
18 and gentlemen, thank you for the invitation this
19 morning. I must admit though that speaking after
20 Karl Rove at a Republican National Convention is a
21 little bit like going to the finest restaurant in
22 town, ordering Chateau Briand, and then being told

1 that you're having Jell-O for desert. It's an
2 interesting time.

3 I'm delighted that the department and
4 the good work of Gail Wilensky and the task force
5 that reported to Congress can now be moved forward
6 in a systematic way that brings value not only to
7 the Department of Defense but, frankly, to our
8 nation. What I'd like to walk you through a
9 little bit is what's happened since the release of
10 that letter which is Tab 4, July 11, directing or
11 asking that Dr. Poland and the DHB set up a
12 process to deliver on the Health Care Delivery
13 Subcommittee of the DHB.

14 You have in the attachments in your book
15 a list of the current members some of whom are
16 here at this meeting of the newly created Health
17 Care Delivery Task Force. Many of them you will
18 recognize as leaders in health care delivery and
19 health thinking. There are additional members
20 that may be added to that group. I'll Roger in a
21 few minutes for an update of the logistics and the
22 formation of the committee itself. We are

1 planning for an initial meeting on October 20.
2 That's the latest date that we're circling in on,
3 so that's the practical logistics.

4 What myself, Dr. Wayne Lednar, and Dr.
5 Poland have tried to do in the intervening weeks
6 since the letter was released was to develop what
7 would be a concept of operations for the committee
8 itself and for the step-by- step process that we
9 would use to bring value to what is a very broad
10 charge. So let me at a very high level walk
11 through some of those principles because the
12 document itself is probably about 90 percent
13 there. I'm not satisfied with it yet, and I don't
14 want to waste the time of either the subcommittee
15 or of the full DHB before going forward. But let
16 me just give you some of the flavors that I think
17 are important to inform this effort and then
18 invite Dr. Poland's commentary, Dr. Lednar, and
19 the full committee.

20 The first is that the subcommittee
21 believes that the military health system can serve
22 as a national model for health care delivery best

1 practices, provide standards based on a population
2 health optimization construct, and serve as an
3 example for existing best practices in the
4 civilian or government sector. The notion of this
5 committee would be both aspirational and
6 transformational. It would not necessarily be
7 constricted by either the recommendations of the
8 MHS task force which had a deliverable back to
9 Congress in a set period of time as we discussed
10 during Dr. Wilensky's report to the full board at
11 one of our past meetings, but it would certainly
12 be informed by those recommendations and informed
13 by existing civilian best practices. But as
14 anybody knows who looks at the U.S. health care
15 system is if your goal is to duplicate a civilian
16 system that has 35 percent pure waste,
17 inefficiency, and ineffective care, than it
18 probably is not the goal for the military health
19 system to emulate but, rather, to learn from and
20 move beyond. So the first thing we wanted to do
21 was to have frank dialogue with Dr. Cassells, Ms.
22 Embrey, and the leadership of the DOD about the

1 role, the charge, and the aspirations, if you
2 will, of the overall vision.

3 The External Advisory Group of the
4 subcommittee believes that the MHS can represent a
5 national model for health and health care
6 transformation informed by but not limited to what
7 may be "current best practice" in the private or
8 non-DOD governmental health and health care
9 related sectors. So that we thought was very
10 important to say up front and get buy in.

11 We certainly want to use as our true
12 north the charge from the Military Health Service
13 task force which talked about the DOD developing a
14 strategic plan for better integration of the
15 direct care system and the purchase care system.
16 The DOD currently, Dr. Cassells and staff, is
17 working on a strategic plan strategic plan in
18 direct response to Dr. Wilensky's task force that
19 will be one of the first missions of the
20 Subcommittee on Health Care Delivery, to review
21 that strategic plan, provide feedback to the DOD
22 as to whether it nor it meets its mark, and then

1 interface that with what will be the scope and
2 mission of the Health Care Delivery task force.

3 We envision, and by we at this point
4 it's the staff, it's also Dr. Lednar and Dr.
5 Poland, that in order to bring value to our
6 effort, we almost have to step back for a minute
7 and define two axes of health and health care
8 continuum which is one axis defined by health
9 behaviors and the supporting healthy communities
10 that lead to this behaviors, acute care, acute
11 episodic care, chronic disease, surgical decision
12 support, inpatient care, rehabilitative care,
13 hospice, end-of-life compassionate care. We're
14 not defining the scope in terms of what happens at
15 an MTF or what happens in a TRICARE contract.
16 It's the needs of the military beneficiaries which
17 frankly should serve as a model for others who
18 might want to learn from an organization that has
19 as its core values fitness, performance,
20 transparency, efficiency, optimization, just as we
21 do a military operation. That's the first axis.

22 The second axis, however, which makes

1 those real is what we call the health system
2 infrastructure continuum. It's the IT. It's the
3 programs and policies and leadership structures.
4 It's organization. It's metrics. It's personnel.
5 It's training. It's best business practices that
6 may or may not be optimal business practices. So
7 in our processes, what we want to bring to you is
8 a roadmap, a CONOPS, a concept of operations, for
9 how the committee will go deliberately over one
10 continuum alternately with another continuum,
11 because you can talk all you want about wellness
12 programs or for that matter doing better
13 monitoring of people on Coumadin to prevent stroke
14 admissions in the emergency room, but if you don't
15 talk about infrastructure to support those
16 evidence-based practices, we won't get there which
17 is something I think we see time and time again at
18 the board where we articulate best practices and
19 we don't get into the weeds enough to be of
20 support to the DOD in terms of infrastructure
21 support to get to those optimizations.

22 The final major construct in the

1 document that will be coming forward to the
2 members of the subcommittee and to the full board
3 is that within each one of those core building
4 blocks which are really functional in nature,
5 they're not defined by the existing laws or
6 statutes or practices, they'll be informed by
7 that, but what is the process whereby we want to
8 look at for example informed surgical decision
9 support in a country where a third of all surgery
10 is unnecessary? How are we going to get there to
11 look at how we bring value back to the DOD?
12 First, review existing MHS service metrics and
13 where DOD stands relevant to civilian best
14 practice benchmarks where they exist. Number two
15 is provide to the committee in advance the
16 relevant DOD benchmarks and civilian benchmarks in
17 advance of our sessions. There will be pre-work
18 before our meetings so that we understand the lay
19 of the land before we actually convene. Number
20 three, pre-work, working with DOD staff and the
21 expert panel members and identify to the committee
22 existing best practices that you are aware of in

1 that continuum sector that we're talking about at
2 that meeting. Is the best practice here? Is the
3 best practice perhaps in the U.K.? Is the best
4 practice in a work site health clinic that DOD
5 doesn't own, operate, or even have? So what we
6 want to do is to find for the group what are
7 existing best practices.

8 Step number four is the actual meeting.
9 So the pre-work would be benchmarking internal to
10 DOD, external benchmarking external to DOD,
11 recognition of existing best practices where they
12 exist. Number four is the meeting to convene the
13 meeting and look at all of those issues in a
14 single meeting. Number five, obviously is to
15 issue preliminary findings in a report in that
16 element and then insist working with staff that it
17 married up to previous reports and findings as it
18 relates to the military health system so that we
19 cannot have a spine that is disconnected from the
20 periphery with reports coming in that don't fit
21 the health care continuum or the health
22 information infrastructure continuum. Often times

1 we find disparate recommendations coming out that
2 aren't really aligned.

3 Finally, provide feedback on a regular
4 basis through Colonel Gibson and the team back to
5 the committee on what is the progress we've made
6 toward implementation of what we consider to be a
7 breakthrough transformational best practice that
8 the committee itself recommended through the DHB
9 to the ASD for Health Affairs.

10 Thank you for listening to this. I
11 thought if I talked it through rather than showed
12 it on a slide that we can understand the construct
13 because many of us have been involved in
14 transforming large system know that it is very
15 difficult. It can be done. But we have to do it
16 in a systematic way that is reproducible and
17 likely to succeed. So that's why are spending
18 some time in getting the blueprint down as to how
19 this Health Care Delivery Subcommittee should work
20 so that we can meet the goals that really started
21 with the congressional charge to Dr. Wilensky's
22 task force.

1 With that let me turn over perhaps a
2 reaction to Dr. Wilensky, a little unfair, and to
3 Dr. Poland and turn it over to you, Greg, for
4 discussion.

5 DR. POLAND: Let me make a couple of
6 comments and then I'll ask Gail and Wayne to make
7 a few comments. Mike has heard me say some of
8 these. I think this is possibly the most
9 important opportunity the board has ever had to
10 weigh in to anything health related. It informs
11 and transcends I believe everything that DHB does.
12 I think it also is nonnegotiable. This is
13 something that in my opinion the nation owes to
14 service members and I think the tenor that you're
15 hearing from us as we plan this will transmit all
16 the way through everything we've done.

17 The next point I think is that this is a
18 critical competency for force readiness and we
19 dare not ignore this. One can find interesting
20 quotes going back to General Washington saying
21 that as young men, now it's now young men and
22 women, contemplate service to their nation, they

1 will look to see how wounded soldiers were
2 treated, and I think we should be informed by that
3 viewpoint. I think it's also fair to say as Mike
4 pointed out, no one has this right yet. So it is
5 both a challenge and an opportunity. There is a
6 competency to innovation and transformation and I
7 think we will try to bring that into these
8 efforts. Don Berwick will be serving on the
9 subcommittee as I understand it. Don has a
10 compass that I've stolen from him many times that
11 shows that truth north in this regard is the
12 patient focus and we'll try to keep that in mind.

13 Finally, I want to make one point. I
14 hope I won't surprise Mike because I haven't said
15 this to him yet. Some of the recommendations may
16 not necessarily be consensus driven. Some of them
17 will, but not all of them. I'd like you to recall
18 the words of Blaise Pascual who said that
19 consensus can sometimes be mediocrity in disguise
20 and is the opinion of the least clever. Given
21 that no one has it right yet, I don't think we'll
22 always have among the board full consensus on some

1 of these recommendations because as Mike said,
2 they are intended to be aspirational and
3 transformational in the true dictionary sense of
4 those words. Mike, I commend you for taking on
5 such a large role and again impress upon the board
6 the singular opportunity that this challenge
7 presents for us. Might I ask Gail and Wayne to
8 make a few comments and then we'll move on?

9 DR. WILENSKY: It's been extremely
10 gratifying to recognize the seriousness with which
11 the recommendations of the task force have been
12 regarded by Dr. Cassells and by the senior
13 oversight group that has been put together by the
14 various surgeons general and now by the charge to
15 your subcommittee in terms of putting some of
16 these directives into action. The focus on the
17 integration of the direct care and the purchase
18 care and how that can be used to provide best
19 practices in the delivery of efficiently produced
20 high-quality care is something that I think really
21 will be very important not just to the military,
22 that is its first obligation, but potentially to

1 the nation as we struggle more broadly to try to
2 understand best delivery. It's I think
3 particularly important that the military because
4 of its use of purchase care and the direct care
5 system which as many of you have heard me say is
6 both the great strength of the military, but it
7 also the big challenge because it requires an
8 integration. But frankly it is that integration
9 which makes it so much more relevant for the
10 country as a whole.

11 There are many things that you can learn
12 from a direct delivery system that shows what
13 systems can do in terms of providing either more
14 efficient or high-quality care and there are a
15 number of systems, both the VA through the
16 government, Kaiser and a number of other systems
17 in the private sector, but the fact of the matter
18 is the vast majority of physicians are in groups
19 that are fewer than nine, about 70 percent that
20 are in four or fewer. Most of us do not as
21 patients or potential patients belong to these
22 systems of care. So my mind what really is the

1 leadership that the military can provide not only
2 in terms of leading the way for providing care for
3 our its members and their families, and that's
4 every bit as important, but it is really to show
5 how the integration of a direct delivery and of a
6 purchase care system which is much closer to what
7 the rest of us have can allow us to get to a point
8 where we are having both slower growth in spending
9 and higher value in terms of the services that are
10 received.

11 It is a very daunting challenge. It is
12 not just trying to get the right incentives in
13 place, but a lot of it now, my other area of
14 activity, I'm trying to press the Congress forward
15 on the notion of a Center for Comparative Clinical
16 Effectiveness, has been the realization of how
17 much we don't know in terms of what works when for
18 whom and under what circumstances and that without
19 that kind of information even the best intentions
20 will make it very hard to achieve the kind of
21 improved value and quality of care that we all
22 want. But it's a big issue for us as a country

1 and I think it really is capturing us at a moment
2 where there are forces on the right and left that
3 are looking at these issues. It's a little hard
4 in the middle of the silly season as you phrased
5 it correctly to recognize that and it will be hard
6 for the next few months, but there are very
7 important common elements in both
8 health care plans as it relates to the
9 delivery system, very large differences as it
10 relates to expanding insurance coverage, but very
11 common elements and that's precisely the area
12 where I think that the military and the
13 subcommittee in particular can provide leadership.

14 So for the 15 of us, and there are
15 several in this room, and General Myers who is
16 also a new member who devoted a fulsome year to
17 try and produce this report, it is truly
18 gratifying to see the seriousness with which this
19 board but particularly the Department of Defense
20 have taken in that. It doesn't always happen that
21 way with task forces.

22 DR. LEDNAR: I guess I'd just share a

1 couple of thoughts. One is that I think we should
2 stop for a moment and just reflect on the fact
3 that DOD and VA have defined high quality and
4 delivered it in ways that have instructed the
5 entire nation and other nations around the world
6 and we should feel very good about that. So I
7 think we have a structure that is up to the
8 challenge but it needs some perspective, it needs
9 some advice, it needs not just hope, it needs a
10 plan that can be executed. So this while it's
11 daunting is entirely doable, and as Dr. Poland
12 said, in fact there's a moral imperative to
13 succeed here.

14 A couple of thoughts I think that have
15 occurred as Mike, Greg, and I have started to sort
16 of kick the tires about how we can help to move
17 Dr. Wilensky's and General Meyers's task force
18 plans forward, one is that we're talking here not
19 just about individual patient medical treatment,
20 we're talking about population health management
21 and those two sources of expertise, medical
22 expertise are not the same and they need to come

1 together in an effective way. Our goal is not
2 just good clinical care, it's also that the
3 mission of DOD can get accomplished, mission
4 focused, and we don't hear that enough in the
5 delivery of medical care, that it's not just that
6 one's coronary arteries are now more patent than
7 they were before we stuck a catheter into them,
8 but that the patient got better and not just
9 clinically, but able to perform tasks of daily
10 living and work, and we need to do that at the
11 individual and also at the group level.

12 So this approach in medical care
13 delivery has to have perspectives of metrics that
14 get at what is this accomplishing and it's got to
15 be more than just spend less, it's got to be more
16 than just clinical outcomes, and clearly more data
17 delivered in best practices ways, but did it make
18 a difference. So there's going to be some need to
19 innovate, and innovate and transform are two words
20 that have continuously been popping in the
21 discussions over the last 6 to 8 weeks. In fact,
22 shame on us if we don't take the opportunity that

1 Dr. Cassells has presented and really deliver a
2 plan to build on the thoughts from throughout the
3 private sector and the VA and the military sector
4 on how to do this well.

5 I guess I'd just close with one other
6 thought. This is partly a personal sense but I
7 think it should be transformed into a Health Care
8 Delivery Subcommittee reality. That is we should
9 have world-class inpatients. We need to get
10 there. And when we think about clinical practice
11 guidelines and the experience today of how long it
12 takes for science-derived best practices to find
13 their way into day-to-day patient care, we cannot
14 tolerate 7 years or some even say 18 years before
15 the science converts into day-to-day practice.
16 None of us should tolerate that and we should have
17 a system ensure that it doesn't occur.

18 DR. POLAND: Thank you, Wayne. Roger?

19 COLONEL GIBSON: Just a couple comments
20 on administration associated with this. One
21 comment, yes, difficult job, lots of work to do,
22 and to make it harder it's going to be a moving

1 target because DOD will move forward. They have a
2 Senior Oversight Council with lines of action
3 associated with this. They will be doing things
4 as this group continues to move, but health care
5 it's evolving. It's an iterative process. We
6 stood this subcommittee up, this Health Care
7 Delivery Subcommittee, in 2007 knowing full well
8 that the Task Force on the Future of Military
9 Health Care would provide a set of recommendations
10 that would need care and feeding, would push this
11 board to get involved to get involved to make sure
12 that things are followed up through the
13 department, and in particular these issues of best
14 practice. So we've put it in place and had a
15 small number of members. Since that time we've
16 appointed 17 members to this subcommittee four of
17 whom are currently core board members. As core
18 board members, any of you who wish to serve on
19 this subcommittee may do so. We have two
20 additional pending members and we're expecting to
21 hear about their appointments shortly. These
22 appointments were confirmed just in the last 20

1 days. So we're moving forward on that.

2 I would also say, and Mr. DuBois may
3 want to comment, that National Capital Region BRAC
4 and the initiatives going on there with Joint Task
5 Force MEDCAP or CAPMED presents an opportunity for
6 a test bed for many of the initiatives that may
7 come out of this.

8 DR. POLAND: Dr. O'Leary?

9 DR. O'LEARY: This is an enormously
10 important initiative obviously and huge in scope.
11 I would just offer a little caution about the
12 illusion of the benefits of best practices. My
13 organization tracked best practices and they're
14 like gossamer, because something that works there
15 is not necessarily going to work here. It's not
16 to say that there are not some gold out there, but
17 if you're really interested in something, you need
18 to find out why it worked there and to make it
19 work here, is that going to be compatible with
20 your mission, with your principles, with what
21 you're trying to do. So best practices is a nice
22 sounding term but it is not the Holy Grail. There

1 is going to be much more gold in leadership and
2 principles, innovation, understanding what you're
3 trying to do. There's nothing to say that you
4 won't be able to build something better than
5 anyone else has built.

6 I would go back to things like the
7 importance of evidence-based design. We're
8 experiencing a major hospital-building boom in
9 this country and I would say close to 95 percent
10 of the hospitals that are being built are being
11 built just like they were before against the face
12 of a huge base of evidence-based design to say
13 that there are a lot of things you can do and do
14 differently that have immediately translations
15 into improving patient safety and health care
16 quality. So I would gravitate more to the world
17 of evidence than to the world of best practice in
18 my own personal opinion.

19 DR. PARKINSON: Dr. Poland, one final
20 comment if I may on Dr. O'Leary's comment is that
21 I think the evolution -- and you see the wonderful
22 makeup of our colleagues, many of you are

1 international leaders in this area, the notion of
2 how do you internalize a sense of cultural
3 competency, values in a system, grow leadership,
4 and this notion Paul Batalden and his team and
5 others have pioneered, the microsystem of care
6 that empowers patients not to being patients they
7 don't need to be and staff to be a team and all
8 those types of things are inherent to the value.
9 So the best practices language, Dennis, comes as
10 much out of the wording all the way back to the
11 congressional language that filtered down. So
12 we're really involved with that.

13 The final comment, Greg, is that several
14 years ago Dr. Dan Fox who is with the Millbank
15 Foundation had a wonderful historical analogy. He
16 said race relations in the United States took a
17 major leap forward when General Eisenhower
18 directed the Department of Defense to integrate
19 and to get rid of the vestiges of racism. He said
20 there is no reason why the clear-thinking people
21 in the Department of Defense with a value-based
22 system around optimal performance at all stages of

1 life can't begin to add value and reshape in a
2 very, very ineffective health care system new
3 values with this type of effort and he actually
4 believed that. So the conversation I had today is
5 good for all of us to hear because in the
6 aspirational transformational vein that we're
7 charging forth with here, I think we should settle
8 for nothing less realizing that there's a lot of
9 economic, political old thinking along the way
10 that we may have to change. But with that, thank
11 you very much.

12 DR. POLAND: Thank you, Mike. We have
13 two briefings for the board actually recommended
14 by Dr. Parkinson, and I commend you, Mike, for
15 suggesting it, to better understand for the board
16 members how some of the financing and other
17 aspects of this works. Our first speaker will be
18 Colonel Jim Black who serves as the Senior Medical
19 Director at TRICARE Management Activity. He'll
20 provide the board with an introduction to TRICARE.
21 We're calling it TRICARE 101. And how the DOD
22 delivers health care through their partnerships

1 with civilian health care systems. We do this,
2 and I recognize some of the board members have a
3 lot of experience and expertise with TRICARE,
4 others don't, so we'll try to give everybody the
5 same background here. I think it's clear that
6 health care delivery issues are of paramount
7 importance to DHB's future direction. I think
8 Colonel Black's slides are under Tab 5.

9 COLONEL BLACK: Thank you very much.
10 TMA is the TRICARE Management Activity and I've
11 been there all of 6 weeks. So last week when I
12 was asked to give this briefing, I said I should
13 be giving the briefing and not giving the
14 briefing. They said, Jim, it's like when you were
15 a resident and you'll see one, do one, teach one,
16 where we're sort of eliminating see one step,
17 weaning the process a little bit. So in any
18 event, here we go. Just an overview of what I'll
19 be talking about. I'll try to make up for the
20 fact that Dr. Parkinson didn't have any slides
21 with my briefing.

22 What is TRICARE? We use the word all

1 the time so I think one of the key words here is
2 it's a health care system with military health
3 care as the backbone partnering with a civilian
4 network of providers and facilities serving those
5 great folks. Every organization has to have a
6 vision and a mission, and this is ours. I think
7 on the mission where it says providing health
8 support, that's anywhere, anytime. Just a little
9 bit more about the TRICARE system. I was told
10 that the entitlement program for someone simple
11 like me means it's law. So TRICARE is in law. It
12 has a consistent benefit throughout the program.
13 I can say in my time at TMA, there are all sorts
14 of regulations and policy manuals. It's amazing
15 the amount of stuff out there that tells you how
16 the program works.

17 Obviously, which was a little surprising
18 to me, Congress says a lot about what is in the
19 benefit, and they may say some things aren't part
20 of the benefit like cosmetic surgery or biatric
21 surgery, those types of things are not a TRICARE
22 benefit, although they may be performed at an MTF

1 especially it's part of the training program. And
2 obviously the congressional interest is focusing
3 on access and high quality care. I think that
4 last phase there at the bottom, families, because
5 again when it comes to retention that families and
6 especially spouses have a very important say in
7 that decision.

8 Besides TMA in providing high-quality
9 care, force health protection is also one of its
10 missions. Part of this is keeping people fit
11 especially service members so that they're fit to
12 fight. Being sure our medics are trained to
13 deploy and take care of our troops that are in
14 harm's way. Being sure that our senior leaders
15 have medical capability in the event of a crisis
16 be it humanitarian or a disaster like Katrina or
17 any kind of conflict. That last one there is that
18 when a member is deployed, we want to be sure that
19 their family is being taken care of stateside.
20 And certainly today with instant access, they can
21 find out very quickly if that's not happening, and
22 certainly that can have an adverse impact on the

1 mission.

2 Any military briefing wouldn't be
3 complete without a wiring diagram. I think this
4 is correct because chemists will start looking at
5 things, solid lines, dotted lines, slashed lines,
6 slashed dotted lines, so I tried to make it as
7 simple as possible, but in any event, the
8 president, secretary of defense, office of the
9 secretary of defense, defense secretary of defense
10 for health affairs is Dr. Cassells. That's where
11 the policy comes down to TMA which provides
12 guidance to the services on executing those
13 policies. You can see that's a dotted line so the
14 medical service departments work for the services,
15 but when it comes to medical issues, many of those
16 policies and guidance come through health affairs
17 and TMA.

18 As far as TMA is concerned, you can see
19 Dr. Cassells is the director and the deputy
20 director is General Granger. The chief medical
21 officer is Dr. Kelly. Then you can see the other
22 areas there in TMA. TRO stands for the TRICARE

1 Regional Office and I'll talk a little bit more
2 about that in another slide. TRICARE Area Offices
3 are to the TRO equivalents overseas, so there's
4 Europe, Latin America, Canada, and the Pacific.
5 I'm under the chief medical officer probably
6 somewhere where the black curtain is I would
7 suspect.

8 There are three regions and there are
9 three contractors as you can see there. This is
10 what the contractors are responsible for and they
11 work with the TROs under the guidance of TMA.
12 This shows the three regions and again the three
13 contractors in the TROs. Each of the TROs are
14 located in those regions. I think in the west
15 it's in San Diego. I don't know why it's not in
16 Minot.

17 Just some facts and figures that may be
18 impressive. I'll talk a little bit more about
19 what prime enrollee means. When you look at the
20 bottom number there, I would suspect that like
21 everything in health care, it continues to go up
22 and up which is obviously a concern to our senior

1 leaders.

2 Here's what happens in 1 week in the
3 military health system. These are pretty
4 impressive numbers. Again when you get down to
5 the bottom, when I say that I said that's a lot of
6 zeroes for a week, but to provide that amount of
7 care it takes a lot of money.

8 Here are some of the DOD health care
9 programs. Don't worry, I'm not going to go into
10 go into great deal on all of these, but I just
11 want to highlight what they are. Some of these
12 have evolved from when originally TRICARE came out
13 in response to various needs. These are the three
14 basic TRICARE options. Prime is an HMO type,
15 TRICARE Extra is the preferred provider
16 organization type, and then standard is the
17 typical fee for service. TRICARE Prime is really
18 the most affordable and the most comprehensive.
19 Enrollment is required but there is no enrollment
20 fee. These are some of the features of Prime. If
21 you're located near a military treatment facility,
22 MTF, you can get enrolled in Prime, or if the

1 regional contractor has set a Prime network, you
2 can get enrolled in Prime there. Again you're
3 assigned to a PCM who helps manage your care.
4 These are the eligible beneficiaries for TRICARE
5 Prime. For active-duty members, they don't really
6 have a choice. They're automatically enrolled as
7 Prime.

8 In the previous slide it talked about
9 access. From what I understand is law so it has
10 to be done, but I can tell you that with the
11 current situation with a lot of folks deployed,
12 providers and nurses and technicians, sometimes
13 it's tough meeting those access standards. So we
14 give money to the MTFs to hire contractors which
15 in some places in the middle of New Mexico or
16 whatever may be a little difficult and more of a
17 challenge. And also even if you're in a more
18 provider-rich environment, you're competing with
19 other health care organizations that may have
20 little deeper pockets. In any event, we have a
21 challenge and I think folks are responding to it
22 and really doing the best they can in sometimes

1 trying situations.

2 Extra again is the preferred provider
3 option. In this one you need to see a TRICARE
4 network provider, and there are a few more details
5 there. Standard again is the fee for service. In
6 this case you don't necessarily have to see a
7 network provider, but you just have to see one of
8 the authorized providers and the options that the
9 provider may have in regard to the claims.

10 One slide puts it all together. You can
11 see Prime, nothing. Extra has annual deductibles,
12 some co- pays, et cetera. In any event, you can
13 see how Prime is really the most affordable of the
14 options. This is the let's make it simple for Jim
15 Black slide, freedom of choice, Prime not to much,
16 more as you go up to Standard, access to military
17 treatment facilities, there's greater with Prime,
18 cost greater with Standard. I can understand
19 that.

20 I think this rolled out with TRICARE
21 about 10 or so years ago. When you roll out
22 things you realize maybe there are other things

1 pop up that we need to address. Again, not every
2 active-duty member is going to be near an MTF and
3 so we want to be sure that for medial-readiness
4 reasons, et cetera, and for deployment readiness,
5 we need to be sure that they get the care they
6 need. There's TRICARE Prime Remote. Those are
7 the criteria to be eligible for it. Apparently
8 the Zip codes are already determined so when you
9 go on the website you just put in your Zip code
10 and it will tell you whether you qualify or not.
11 Also it can be available for the active-duty
12 family members if their sponsor is in a remote
13 location, but it's only available in the 50 United
14 States.

15 There's TRICARE Prime Overseas. Again
16 it's the same kind of benefits that TRICARE Prime
17 Stateside has. It makes it easier to transfer
18 between regions from Europe. If you're going to
19 west region, TRIWEST, your enrollment, and you do
20 have that point of service option overseas. Then
21 there's TRICARE Global Remote Overseas which I
22 don't really know too much about, but again there

1 are folks assigned to remote overseas locations
2 which kind of makes sense. But it will be
3 partnered with International SOS which I really
4 didn't know too much about, but there will be
5 another slide to talk about that organization. In
6 any event, there's a license of (off mike) and
7 qualified physicians who have been identified that
8 members can go to for their care.

9 So here it is. I think in looking at
10 their website, it's a 24-hour operation. They
11 have several thousand physicians, nurses, and
12 technicians, aeromedical specialists and DOD has
13 contracted them to provide this service. TRICARE
14 For Life. When TRICARE first came out, when you
15 turned 65 and were eligible for Medicare, you were
16 no longer eligible for TRICARE. That got the
17 retirees a little stirred up and so I think in
18 2001 Congress responded to that concern and so
19 enacted TRICARE For Life. There's a whole slew of
20 things that you have to think about. Besides
21 being in enrollment, also Part A and Part B you
22 have to be enrolled in, but you have to pay the

1 Part B medical premium and not the hospital Part
2 A.

3 This goes into what Medicare will pay
4 for and TRICARE won't, what TRICARE will pay for
5 and Medicare won't. If neither of them will pay,
6 you have to pay for it. The one thing that I
7 really want to focus on is the bottom bullet which
8 is TRICARE Plus because TRICARE For Life you're
9 only eligible for space A care at our MTFs.
10 TRICARE Plus is a program that if there's capacity
11 at the MTF, you can be enrolled for primary care
12 appointments, but it's really up to the discretion
13 of the MTF commander if they have that capacity.
14 It's a way at least for the folks with TRICARE For
15 Life do have an opportunity to try to get at least
16 their primary care done at an MTF but it doesn't
17 guarantee them specialty care at the MTF. Again I
18 think this is one of our more popular programs,
19 the pharmacy program.

20 As everyone knows, pharmacy is many
21 times an expensive choice some patients have to
22 make, but for our program, the generics is not an

1 equivalent, then you go to brand name. If they're
2 nonformulary you need the medical necessity and
3 prior authorizations. Sometimes they may have
4 limits on how much they give you and for how long.
5 But the MTF pharmacies have a uniform formulary
6 that to dispense just generic and formulary
7 medications. You can see why this would be a
8 popular program, that if you get your medications
9 at the MTF pharmacy there is no cost. Even the
10 NMOP, the mail-order pharmacy is very reasonable.
11 Even if you go to the retail network, even though
12 you can get a 30-day supply, it's still pretty
13 reasonable. So when you look at that you can see
14 why sometimes people will drive hundreds of miles
15 to come to an MTF pharmacy to get their
16 medications. I'm not sure what year these numbers
17 came from for commercial organizations, et cetera,
18 but in any event, just for comparison, I would
19 suspect for any length in the past they've only
20 gone up, but you can still see TRICARE payments
21 are still low and have been low for many years.

22 To rapidly go through some of these

1 other programs, there's the TRICARE dental program
2 for family members. Again you pay your premium.
3 There's a retiree dental program. Again you pay a
4 premium. There's TRICARE Reserve Select so if
5 you're a reservist you do have an opportunity if
6 you elect to to be part of this program. Again
7 there's a premium payment and you can see the
8 bullet there what the premium payments are, and
9 then the qualifications for the TRICARE Reserve
10 Select. This gives the reserve component a health
11 care option versus many times they will have
12 TRICARE when they're activated on active duty and
13 when they're demobilized they have no health care
14 plan so this gives them an option.

15 Again this program here is when you are
16 separated from the service your TRICARE benefits
17 end. Congress decided that we need at least some
18 kind of transitional program, so for up to 180
19 days you can still get the TRICARE basic options
20 depending on what you have for that 180 days. For
21 involuntary separation, and example would be if
22 you're passed over for promotion a couple of times

1 or if there's a reduction in force and you wanted
2 to stay in but you can't, at least for that period
3 of time you do have a continuum of health care.

4 This program is not actually a TRICARE
5 program but it was something Congress decided to
6 do. It's managed by a contractor and even if you
7 were on the previous program, the TAMP program,
8 when that ends you can still start the continued
9 health care benefit program. As you can see, the
10 premiums there, I don't know how that compares to
11 the civilian world as far as premiums are
12 concerned. It probably seems pretty reasonable.
13 But again an option that someone can look at as
14 their transitioning into their civilian job and
15 civilian health care that they're able to join.

16 I think this is the last one and this
17 one is a program for service members who have
18 special needs family members. This augments the
19 TRICARE Benefit Program. There are various
20 benefits that it covers like rehabilitative
21 services and certain assistive technology devices
22 and things of that sort. You can see what the

1 benefit allowance is. There is I think a payment
2 and it's based on grade or rank. If I remember
3 correctly, I think for a junior enlisted it was
4 \$25 a month, so for that program it's very
5 reasonable.

6 That's kind of quick down and dirty. If
7 you wanted basic, I guess you picked the right
8 person because that's about all my TRICARE
9 knowledge. But in any event, if there are any
10 questions anyone may have you can ask Dr. Kelly.

11 MR. UNTERMEYER: Colonel Black, under
12 what circumstances would a retiree use TRICARE
13 versus VA versus Medicare?

14 COLONEL BLACK: I think for the VA it's
15 going to be service connected. I think the VA is
16 only going to provide care for a service-connected
17 condition. So if you have hypertension and that
18 wasn't service connected, then I don't think the
19 VA is going to provide that care. Medicare is 65
20 and over, so I think Medicare is the first payor,
21 help me Dr. Kelly, and then TRICARE For Life is a
22 wraparound to the Medicare benefit.

1 DR. KELLY: Once you're eligible for
2 Medicare, then the TRICARE For Life program will
3 provide a supplemental insurance so that there is
4 essentially no cost for services that are covered
5 by both Medicare and TRICARE which is most, but
6 there are a few exceptions. People who have a
7 choice, if they're VA DOD so you're a retiree, if
8 it's service connected there's no cost share most
9 of the time in the VA. However, other things, you
10 have a cost share that's based on a needs
11 assessment and your income. So you could have a
12 service-connected disability that the VA would
13 cover, you could go to the VA for that. They
14 probably would treat you for other things too, but
15 then there would be cost shares associated with
16 that. Whereas the cost shares if you're in the
17 military health care system are more clearly
18 defined. Some of that depends on where you are.
19 If you're in a location where there are no
20 military facility and you're going to have to use
21 Standard, you know that there's a 20-percent cost
22 share. If there's VA care it's probably less than

1 that. So it's actually site specific, disease
2 specific, person specific, on whether or not you
3 would choose that and we have benefit advisers who
4 work with people to make sure that they know what
5 the benefits are so that they can make an
6 intelligent choice.

7 DR. POLAND: Dr. Halperin?

8 DR. HALPERIN: Just to understand the
9 system a little bit better. Are there mandated
10 health benefits in TRICARE? For example, HPV
11 immunization or screening for ovarian cancer,
12 things that are sometimes included and sometimes
13 excluded from the normal Blue Cross/Blue Shield
14 kind of thing?

15 DR. KELLY: For active-duty people we
16 have the ability to mandate where you can't say
17 no. For the retirees, for the family members,
18 essentially all of the immunizations that are
19 recommended are covered including up to -- there
20 are technical details about the varicella vaccines
21 because of how it's given that it has been a
22 frustration, but it is a covered benefit, so all

1 of those are covered. We actually have some
2 studies to look at some pilot programs to see
3 about providing without cost share certain
4 preventive services. Those should within the next
5 year hit the street for those people. But the
6 active duty and the active-duty family members
7 don't have a cost share. The retirees for that
8 small period between the time you retire and the
9 time you turn 65 do.

10 DR. POLAND: Dr. Lednar?

11 DR. LEDNAR: A substantial part of our
12 military fighting strength is in the Reserve and
13 the National Guard. Your description around
14 TRICARE described active duty, what's available
15 for the Reserves, also retirees. Can you say a
16 word about what are we doing to support the needs
17 for those in the National Guard if anything?

18 COLONEL BLACK: I think when I said
19 Reserve I was really talking about the Reserve
20 component which includes not only Reservists but
21 also National Guardsmen. So when you see Reserve,
22 that really is the Reserve component that has

1 those two in it.

2 DR. LEDNAR: Then would it be fair to
3 say that this federal thought process around the
4 Reserve component would apply to the National
5 Guard elements which really are under the
6 authority of the individual states? So this would
7 be a uniform program that's available to National
8 Guard folks wherever they're located?

9 DR. KELLY: Yes.

10 DR. LEDNAR: And no?

11 DR. KELLY: There are some states, and I
12 believe Maryland is one of them, that has actually
13 has actually two parts of the National Guard.
14 They have a part that can be federalized, and they
15 have part that's strictly a state militia. The
16 constitution allows that. And so that state part
17 does not fall under this kind of health care
18 policy. But any of the ones who could be
19 federalized do fall under the same rules and it is
20 for the National Guard and the Reserve forces.

21 DR. POLAND: Go ahead, Dr. Wilensky.

22 DR. WILENSKY: To continue the response

1 that Dr. Kelly just made, one of the
2 recommendations of the task force had been to
3 assess how well the changes that were introduced
4 in the last couple of years for the Reservists
5 broadly speaking affected their access to health
6 and therefore their military readiness. A lot of
7 change has occurred. It is very early yet to be
8 able to assess whether or not it has done what the
9 Congress it had done or hoped it had done. So
10 sometime in the next 2 or 3 years it will be
11 important to go back, assess whether or not the
12 Reservists are improved in terms of their military
13 readiness as a result of this or accessing health
14 care in a way that makes it more effective, but
15 it's hard to tell now because we're in the midst
16 of the change.

17 DR. KELLY: Yes, ma'am, and I would just
18 add to that that actually we were directed to
19 reevaluate the cost shares that we had because
20 fewer people were taking that than were projected
21 and so we are going to be lowering those cost
22 shares for the Reserve Select program as we go

1 out. We don't have big data, but we know that not
2 as many took the program as we thought.

3 DR. POLAND: One more question and then
4 we need to stop.

5 DR. FOGELMAN: Could you speak to
6 mental-health coverage and behavioral-health
7 coverage? Is it similar to, different from,
8 somatic coverage? How is it managed? What are
9 the limitations on it?

10 COLONEL BLACK: Dr. Kelly?

11 DR. KELLY: It is similar for outpatient
12 services. In most cases we think of people who
13 are enrolled have to have a referral in mental
14 health before you go to specialty care. However,
15 in mental health you're allowed eight visits
16 before you have to get a referral. If you need
17 more than eight visits, that needs to go in and be
18 evaluated.

19 DR. FOGELMAN: You mean reviewed? And
20 if so, by whom?

21 DR. KELLY: It would be the primary-care
22 manager. Getting the feedback from the

1 mental-health provider to see why they were there.
2 We normally require a referral for anyone who is
3 sent out to specialty care.

4 DR. FOGELMAN: Using what standards in
5 mental and behavioral health to make those
6 decisions about whether more than eight visits are
7 appropriate?

8 DR. KELLY: It would depend on the
9 diagnosis, the treatment, the individual. You're
10 asking for a list and I'm not going to give you a
11 list off the top of my head.

12 DR. FOGELMAN: I honestly was asking
13 conceptually, but I guess the Psychological
14 Services Subcommittee will talk about that.

15 COLONEL GIBSON: We can go into this in
16 the Psychological Health Subcommittee.

17 DR. POLAND: Colonel Black, thank you
18 very much.

19 COLONEL BLACK: Thank you, and thank
20 you, Dr. Kelly.

21 DR. POLAND: I'm pleased to present our
22 next speaker, Mr. Al Middleton who serves as the

1 Acting Deputy Assistant Secretary of Defense for
2 Health Budgets and Financial Policy as well as
3 Acting Chief Officer of TRICARE Management
4 Activity. In this capacity he serves as the
5 principal staff assistant and adviser to the ASD
6 for Health Affairs and for of the departments'
7 financial policies, programs, and activities for
8 the military health system. His bio and slides
9 are also under Tab 5, and we have also allotted 30
10 minutes for this presentation.

11 SECRETARY MIDDLETON: Thank you very
12 much. For some of you this will be a review of
13 material that you've seen before in various forms.
14 I'm sure Dr. Wilensky could actually give this
15 presentation she's seen it so many times, and for
16 some of you this may be new information. We have
17 a fair amount of material to cover in 30 minutes
18 and I'll try to be judicious with your time and
19 leave some time for questions as well. I'm going
20 to talk about these basic things. I'll go through
21 these topically and explain where we are from a
22 financial perspective in the military health

1 system.

2 Organizational relationships, you've
3 probably seen some of these charts before. My
4 responsibility falls on the left-hand side as the
5 principal financial adviser to the Assistant
6 Secretary Dr. Cassells and also as the chief
7 financial officer for the TRICARE Management
8 Activity, and we work in relationship with our
9 colleagues in the services on the financial, and
10 I'll show you some information on the financial
11 flows as well later in the presentation. You've
12 seen this before. This is our mission. We tie
13 ourselves to these things, and I'll look at our
14 goals and objectives as we go forward.

15 Our military system is comprised of
16 three basic components. I think some of you have
17 seen this presentation. We developed this some
18 time ago to show how we moved from our peacetime
19 system to get ready to go to war and then our
20 ability to meet the wartime requirements as a
21 military health system.

22 This is a snapshot of where we are.

1 This contains all the vital information that
2 you'll need to understand how big a system it is.
3 The current total obligation budget authority
4 including all of our components, and I'll detail
5 those components later in the presentation for the
6 military health system is approximately \$44
7 billion on an annual basis. We have approximately
8 62 inpatient facilities, over a thousand
9 outpatient facilities, dental and veterinary
10 services in various clinics of different kinds.
11 We operate with about 132,000 in the military
12 health system and that includes both the military
13 and the civilian forces. And we serve about 9.2
14 million beneficiaries. That would be both the
15 active duty, their dependents, retirees, survivors
16 of retirees and the dependents of those folks, so
17 fairly large system, a global system, care
18 provided or paid for essentially around the globe.
19 So it's a big, complicated system. In fact, the
20 TRICARE management at the MHS conference last year
21 in my comments I think I accurately portrayed this
22 as probably the most complex health system in the

1 world.

2 Let me talk a little bit about
3 beneficiaries and benefits. I know you just had a
4 presentation about that. This gives you a
5 breakdown of the categories of people of our 9.2
6 million beneficiaries. As we trend that out over
7 the years as you look out, the projections are
8 that that stays in that same ballpark. Some years
9 it gets to 9.1, others it goes to 9.2. Of course,
10 contingency situations, recruitment, retention,
11 all of those will play a factor in what our
12 ultimate and over the years what our total
13 population is, but you can see the general
14 population. The Medicare eligibles, and I'll talk
15 a little bit at the end of the presentation about
16 how we finance. Someone asked the question
17 earlier about TRICARE For Life. I'll talk briefly
18 about TRICARE For Life and how we finance that.
19 It's a fairly unique way in which we finance that
20 health care for our folks who are Medicare
21 eligible. Sometimes we think of that as being
22 over 65. Really it's all Medicare eligibles, and

1 we have over 100,000 people who are under the age
2 of 65 who are beneficiaries of ours who are
3 Medicare eligible for other medical conditions and
4 disabilities.

5 This may be a little bit of an eye
6 chart, but it'll give you an idea of how this
7 benefit evolved, and I think that's an important
8 story. One of the key issues that Dr. Wilensky
9 and her folks, General Corley and the co-chairs
10 and the members of the task force dealt with was
11 how we're going to deal with financing the benefit
12 long term. The euphemism that we used a couple
13 years ago in our proposal was sustain the benefit.
14 I'm not so sure that's the right euphemism to use,
15 but it's how do we sustain ourselves over the long
16 haul at an ever-increasing rate, and I'll show you
17 some dollar figures to show you the rate of growth
18 in the military health system and how that impacts
19 on the military, the Department of Defense. But
20 you can see a fairly long-term increase in
21 benefits over time starting out with the 1950s and
22 then of course with the implementation of Medicare

1 in 1966, and then the implementation therefore of
2 what we called CHAMPUS at the time, TRICARE now.
3 You see a big benefit change in 2001 principally
4 driven by a couple of things. The TRICARE For
5 Life benefit for the folks who are Medicare
6 eligible was a big-ticket item for the department
7 and a big cost for the department in several
8 different ways, and I'll explain how that gets
9 financed. The catastrophic cap was reduced. We
10 lost the ability to use nonavailability statements
11 in some legislation about that period of time.
12 That all created an increase. So if you look at
13 the trend of dollars for the military health
14 system you can see this gigantic jump starting in
15 about 2001 to get us to about \$44 billion. It was
16 \$19 just about 6, 7, to 8 years ago, so a big
17 jump.

18 I'll say a little bit about the
19 financial resources. I apologize, we have two
20 slides in there that are the same so let me skip
21 to the second one. Let me talk a little bit about
22 the Defense Health Program appropriation. The

1 Defense Health Program is distinct from the
2 unified medical budget. The unified medical
3 budget includes the Defense Health Program. The
4 Defense Health Program is an appropriation by
5 Congress separate and distinct from the rest of
6 the department, and that's an important
7 distinction because under fiscal law we're unable
8 to exchange dollars between different
9 appropriations without congressional approval so
10 the money that we get is the money that we get and
11 so we have to live within that confined budget.
12 It's important for you to understand as you get
13 further along into the Defense Health Board
14 programs and the subcommittees that the DHP is an
15 appropriation. It includes our operations and
16 maintenance dollars, ONM dollars, our procurement
17 dollars for equipment and systems over \$250,000,
18 and our research and development, testing, and
19 evaluation dollars that we manage. We may carry
20 money over on the ONM side from year to year but
21 not more than -- it was 2 percent, this year
22 they've reduced it to 1 percent for us. We'd like

1 to get that turned around and we might need your
2 help to do that. Also part of the uniform budget
3 is the Defense Health Program Military Personnel
4 Accounts in programming which is the out years.

5 As we look at our fiscal program, we
6 have essentially three things going on at the same
7 time. We have the execution year, the fiscal year
8 that we're end and we'll end that in about 26
9 days, we'll end this fiscal year. That's the
10 execution year. We have the budget year which is
11 the president's budget year which will be FY09
12 starting 1 October. Then we have the out years,
13 FY10 to FY15. Those are what they call the
14 programming years. So if you think about it, we
15 have spending, defending, and pretending. But in
16 the pretending stage of this, all people are
17 dollars. So in FY15 from a programming spectrum
18 I'm just a dollar and Colonel Gibson dollar, and
19 in the programming years we can convert those
20 military to civilian, to contractors. We can move
21 those dollars around. In the execution year we
22 can't, and in the budget year once the president

1 submits his budget we're pretty well locked into
2 what we're going to have. So there's not a lot of
3 change that goes on in that. But in the
4 programming cycle, a source of funding, you think
5 of people not being funds, in the programming
6 years they really are funds.

7 We have military medical construction
8 and I'll give you a little more detail about that
9 later on. The Medicare Eligible Retiree Fund,
10 I'll talk a little bit about how we finance the
11 folks who are Medicare eligible. We do get a lot
12 of supplemental appropriations, the global war on
13 terror being the most obvious. Lots and lots of
14 money. Billions of dollars coming into the
15 Defense Health Program to help buy down the bills
16 for our people who are deployed and so we can
17 bring care back into the facilities using
18 contractors or overhire civilians or anything else
19 we can do in order to pay for that care that goes
20 downtown.

21 We also have hurricane relief, Hurricane
22 Katrina being obviously one. We don't know if

1 there will be a call for Gustav or not. But in
2 Hurricane Katrina as you all know because Keesler
3 Air Force Base hospital, the 81st Medical Group
4 was essentially wiped off of the Biloxi Peninsula
5 down there and had to be rebuilt, and that took a
6 lot of money so we get money from that. Then
7 things like pandemic influenza. As we look at the
8 avian flu going forward, there are supplemental
9 dollars that come in to allow us to buy Tamiflu
10 and vaccines and other things like that.

11 Currency fluctuation is one of the areas
12 where we do have reprogramming. We were unable to
13 spend all of our money and it's not lost to the
14 Treasury which is usually the thinking that goes
15 on. The department has an enormous amount of
16 currency fluctuation as it buys and sells
17 commodities and issues and things around the
18 globe. We are able to contribute to that fund
19 along the way. We like not to do that because
20 that's money lost to us, but we are able to use
21 that as well. We can actually receive money if we
22 can show that we have costs in that area. And we

1 have special programs, the emergency AIDS relief
2 program for the president. Then we have a DOD
3 incentive fund. The Department of Defense and the
4 Department of Veterans Affairs puts money in every
5 year. It's \$15 million minimum. We can put more
6 in against initiatives. We have two different
7 kinds of programs for incentives. One is to deal
8 with local issues so that local commanders have
9 access to a pot of money to do local missions with
10 their local VAs to bring care back in, to do
11 better care, quality care, those kinds of things.
12 We have also another program where we can actually
13 do global kinds of things where we want to share
14 things at the enterprise level, so that's an
15 opportunity for us to get money into our programs
16 as well. We get grants and research dollars of
17 course. We get gifts like the Fisher House. We
18 are able to take those on and certainly for the
19 Center for the Intrepid as you know built the San
20 Antonio down at Fort Sam Houston, and also as you
21 know is building the Center of Excellence out at
22 Bethesda next to Walter Reed National Military

1 Medical Center. It's going to be a magnificent
2 source of service for our wounded warriors. Then
3 we get some line funding primarily through
4 readiness issues and service-funded medical
5 personnel, headquarters functions and things like
6 that. So all of that goes into the pot of money
7 that we construe as our \$44 billion.

8 Just to give you an idea of what these
9 dollars mean for those of you who are not familiar
10 with this, and I'll go through this quickly. It's
11 in your materials. I think we made it readable
12 enough that you can look at it at your
13 convenience. The operations and maintenance
14 really takes care of the worldwide operations of
15 the medical, dental, and veterinary services. It
16 takes care of the management activities,
17 occupational and industrial health. It takes care
18 of the information-management portions of it that
19 are not procurement. For medical research we have
20 Central IM/IT projects. It takes care of a lot of
21 the Air Force initiatives like disease
22 surveillance. And they have a pilot vision. I'm

1 sure the Air Force folks can tell you about their
2 supervision example. Plus we get a lot of dollars
3 from the Congress on the congressionally directed
4 research programs. The House mark this year which
5 I don't think is top secret is nearly a billion
6 dollars in medical research. A lot of money,
7 including a lot for psychological health and
8 traumatic brain injury which I know you know is a
9 big issue for us. A lot of dollars. It's House
10 marked. It's got to go through full committee and
11 it's got to go through the process, but the mark
12 is fairly substantial. Then procurement is just
13 for those items over \$250,000, big-ticket items
14 that we have to buy, most of the equipment, but
15 expensive medical equipment or
16 information-management technology systems which
17 are considered to be under procurement.

18 To show you how the funds flow, people
19 want to know how the money comes. Congress
20 appropriates of course, OMB apportions. The
21 comptroller in the Department of Defense then
22 allots us money on a quarterly basis. We then

1 receive the money in the TRICARE Management
2 Activity. After we are able to analyze the
3 requirements we issue the money to the service
4 surgeons and then to the TRICARE financial
5 operations to pay the private-sector care bills
6 and then the services distribute the money down
7 through their intermediate commands and down to
8 the MTF level, so that's how the money flows down
9 from us on down.

10 To give you an idea of the size of the
11 current budget, this is as of last week or so what
12 our appropriations looked like to get to that \$44
13 billion I was talking about, you can see the
14 relative size at the very, very top at the ONM
15 side of the Army, Navy, and Air Force, and that
16 gives you a pretty good idea of the size of their
17 accounts, with the Army obviously being the
18 largest at about \$6 billion, the Air Force being
19 the smallest at \$2.7 billion. In the TRICARE
20 Management Activity, about \$12 billion of that or
21 so goes out toward the purchased care to buy care
22 that's provided downtown, either the care that's

1 referred downtown or for those people who decide
2 to use our Standard benefit who go downtown to get
3 their medical care. You can see the rest of the
4 accounts. MILPERS is what's the personnel cost of
5 the military personnel, military construction are
6 those large projects like building new hospitals
7 and clinics, and you can get an idea of what
8 that's going to be. We have some money in the
9 TRICARE management too to handle BRAC this year.
10 We have BRAC expenses that we're managing out of
11 the TRICARE Management Activity. The medical and
12 clinical components of BRAC come under our office
13 in health budgets and financial policy. The
14 MERCHCF is the money that we pay for the folks who
15 are Medicare eligible. Then there are some
16 MILPERS costs that we reimburse the facilities for
17 care that they provide to the (off mike) you can
18 see the size of the facilities, 62 on the
19 left-hand side, 62 inpatient facilities and
20 various clinics, et cetera, and how many people.
21 That's the bill until we get to 132,000 people who
22 are out there. You notice that does include

1 contractors, and there is a sizeable number of
2 contractors who work in our facilities, and that's
3 growing as we provide more capability particularly
4 in the mental-health area where we try to find
5 contractors and other people who will come in and
6 provide services in our facilities.

7 I'll give you a bit about the structure.
8 You can see about 79 percent of the budget goes
9 toward patient care and the rest of it goes into
10 these Budget Activity Groups, and I can go through
11 those very quickly to save some time for
12 questions, but that's the total amount for the ONM
13 piece of the budget for FY08, about \$25.3 billion.

14 Quickly I'll go through these budgets
15 that we manage through seven Budget Activity
16 Groups. These are just pockets where we keep
17 money. It's important to note one thing. Once
18 Congress appropriates the money into the Defense
19 Health Program, it specifies in the appropriations
20 law how much money goes into bag one which is the
21 care that's provided at the MTFs. No money can
22 come out of that bag, Budget Activity Group,

1 without congressional approval. We pay this on a
2 perspective payment system. We have a value
3 premise that we work with with the services to say
4 based on the workload they produce, here's the
5 funding that they get. So it is a perspective,
6 it's not just here's your money and we'll see you.
7 We try to manage the money, work with them with
8 the money going forward to create a financial
9 mechanism for the TRICARE system that emphasizes
10 the value measures that we're looking for. It's
11 based on productivity. The facilities build
12 business plans. We do base it on market value.
13 And we compute it at the MTF level, we allocate
14 those dollars out down to the service level and
15 then they make those adjustments as they give
16 their money to the facilities.

17 This year we've added some pay for
18 performance. At midyear we did some quality
19 adjustments based on the HEDIS-like measures of
20 this year. We sent out about \$7.2 million on that
21 basis. We did it at the end of the year a couple
22 weeks ago another \$50-some million based on

1 additional measures and metrics so that there's an
2 incentive across the spectrum. We used to
3 calculate everything based on productivity. We
4 tried to move that to more value based where the
5 numerator of that quotient is more about
6 productivity plus quality of care plus customer
7 satisfaction, so we try to calculate some value in
8 each of those and give that out as an incentive
9 for the facilities to earn more money based on the
10 outcomes. We used to be simply a
11 productivity-based system. Value was productivity
12 over cost. That's not the way to do it. We
13 wanted to add more quality issues and not just
14 productivity as well as customer satisfaction. So
15 this is the direction that Dr. Cassells has taken
16 us to and it's probably the right approach.

17 I wanted to go back to private-sector
18 care. This is bag two. As I mentioned, we cannot
19 take money out of bag one and move it anywhere.
20 We also are restricted by Congress from putting
21 money into bag two. In other words, we can't take
22 it out of bag one which is the direct-care system,

1 we can't put it into the private-sector system.
2 That causes us to have some budget anomalies that
3 are difficult sometimes to deal with, that we have
4 to then if you think about it, if all the money
5 you had in that bag was all the money you can have
6 in that bag, that means you have to fill that bag
7 up right up front because you can't take the risk
8 because you can't add money to it. That requires
9 us to keep money in bag two for a long period of
10 time. For example, this summer have this every
11 year in our finances in our claims, we have a
12 summer bump. As the TRICARE system turns its
13 people over we always see a summer bump. This
14 year we saw the summer bump and then we saw
15 another trend, so we're seeing an emerging trend
16 of increasing private-sector care. I've got to
17 hold that money back until I make sure that we
18 don't need any more because if I needed any more I
19 have no way to go get it. So we have some budget
20 anomalies that Congress restricts our hands a
21 little bit on that we have to deal with.

22 I want to show you some cost drivers in

1 private- sector care. There are several factors,
2 and the task force was briefed on this on several
3 occasions, that are going on here. As you can see
4 on the right-hand side, the curve for
5 private-sector care, you can see the relative
6 workload through 2007 in the TRICARE system versus
7 private-sector care. So you're seeing a slight
8 flat line on the TRICARE system. Workload is
9 relatively flat. It's a little bit up in 2008, so
10 there are (off mike) that go across, but it's
11 relatively flat. But you can see there's a big
12 increase since 2004 in the workload that's going
13 downtown that's being bought on the purchased-care
14 side and that's driven by several factors one of
15 which is the benefit. The benefit that we offer
16 and I think that was briefed to you in terms of
17 the co-pays and deductibles is by any measure
18 generous. You can argue on which side of that
19 scale generosity is on, but it's generous. So
20 what we find and have found, as private-sector
21 care insurance premiums have increased over time
22 that TRICARE as a benefit particularly for our

1 retirees, our working-age retirees, has become
2 much more attractive. So what it's done is it has
3 acted like a magnet to bring folks back into the
4 TRICARE system. So they're dropping their other
5 health insurance and coming back to us which is
6 certainly their perfectly legitimate right to do
7 so. But we're seeing that new user effect. We're
8 also see the utilization effect. Utilization of
9 the services in private-sector care has increased.
10 Our co-pay of \$12 if you're in Prime and go
11 downtown, a reasonably low deductible cost, et
12 cetera, really has not been a disincentive for
13 utilization either. For those of you who work in
14 the commercial sector, you may have seen that in
15 the commercial sector where you've seen
16 deductibles increasing, you've seen co-pays
17 increasing, and that may have had a mitigating
18 effect on your patients in terms of -- we haven't
19 seen that effect. We've continued to see
20 inflation like all of you in the civilian sector.
21 We are not insulated from inflation any more than
22 you are. We've seen new benefits that have been

1 added to our program, and I showed you that slide
2 earlier about all the benefits that have been
3 added, and the Congress and the department have
4 argued for those benefits and have won those
5 benefits fair and square, but they don't come at
6 no cost. There's pressure on the system because
7 of the increasing benefits.

8 What we've seen is a shifting of
9 workload from the TRICARE system really to the
10 private care system as well as an increase in the
11 private-sector care system as people become more
12 used to private-sector care. If you go back 10
13 years ago when TRICARE started, there was a great
14 resistance to being forced out into private-sector
15 care. People didn't understand it. They didn't
16 want to go downtown. They didn't have
17 out-of-pocket costs. They didn't want enrollment
18 fees. But a decade later now in 2008, we're
19 getting pretty accustomed to it and so
20 beneficiaries are getting used to it and the
21 commercial industry has responded to it, so access
22 is good, quality is good, customer service is good

1 as well. So we're in a competitive environment
2 for where the workload is going to go. Those of
3 you who are on the business panel, we'll begin to
4 see more and more of this as you get to move
5 forward in your panel and understand some of the
6 pressures that are on the system going forward.
7 This is to give you an idea on the market share
8 analysis that gives you a snapshot of how we've
9 lost a little market share compared to others.

10 The war is going on. We all understand
11 that. All of us understood this in 2003. There's
12 been a lot of pressure on this system. We've had
13 a lot of deployments. A lot of the readiness
14 platforms have lost people. Those are our
15 most-capable facilities, the larger facilities
16 with all the specialties, those are the ones who
17 get deployed the most. There's been pressure on
18 the system so we've lost a little bit of market
19 share and that's continued to increase our costs.

20 Again a graphic way of looking at that,
21 you can see the cost structure. We've continued
22 to put money into the direct-care system to

1 sustain it as best we can through the
2 supplementals. They get a fair amount of money in
3 supplementals to sustain that workload and we've
4 been successful in sustaining that workload but
5 it's still driven increasing costs to the
6 department. So as you look out in the out years,
7 and this is an issue that I think we're relying
8 upon your voice on, is in the out years as we look
9 out to 2015ish or so, we start to look like about
10 12 percent of the department's top line. Of the
11 total budget in the Department of Defense, we're
12 going to go from about 4 percent not that many
13 years ago to about 12 percent. Those are dollars
14 that are not being used for other sources in the
15 department and those are dollars, frankly, that we
16 have to be very judicious about because we are
17 using other people's money. These are dollars
18 that 5 years ago were programmed for other
19 purposes. So where we can be as efficient as we
20 can be, where we can get the most amount of care,
21 quality and customer satisfaction out of every
22 dollar, that's where we need to be as an

1 organization and as a military health system
2 because it is going to be enormous pressure. And
3 I don't think we're going to be divorced from --
4 all of you have heard David Walker, the former
5 comptroller speak. He's very eloquent I know. He
6 and Warren Buffett got into a debate I guess not
7 long ago up in Omaha or some place about this
8 issue. Buffett has a different view of it, Walker
9 has a different view, about entitlements in this
10 nation about where we're going and where we're
11 going to be in 4, 5, 6 years on entitlements in
12 this country. The military health benefit is by
13 definition an entitlement although our budget is
14 scored as discretionary, unfortunately, by all the
15 Department of Defense's budget it is scored
16 discretionary and that's an important distinction.
17 Therefore it is subject to come other pressures.
18 Our benefit is scored as discretionary as well
19 even though it's an entitlement. Therefore, the
20 kinds of pressures on entitlements that are going
21 to cause this next administration that comes on to
22 have to look at all of the entitlements in this

1 country, we're not going to be immune from that
2 and there are going to be those kinds of pressures
3 on the department and we're going to have be
4 reactive to those. We're hoping that you can
5 provide advice and the business panel can provide
6 advice going forward and what we can do, where we
7 can be. The Task Force on the Future of Military
8 Health Care laid out some options for some savings
9 around the benefit and other areas about where we
10 could be efficient. The Quadrennial Commission on
11 Compensation also came out with recommendations
12 and if you haven't seen that we can certainly
13 share that with you on the benefit structure.
14 They got to a simple place, a different route,
15 interesting how they got there. But there are
16 pressures here and we're going to need your advice
17 going forward.

18 I'll just go through the bags.
19 Consolidated health, as you can see, it's not a
20 very big budget activity groups but it handles
21 things like the MEPS stations, our occupational
22 health issues which are very important, all of the

1 veterinary services which are managed by the Army,
2 of course, the Air Medical Evacuation Program, and
3 the Armed Forces Institute of Pathology.

4 Information management is what it is.
5 It's a big account, over a billion dollars, but it
6 handles all of the central accounts for things
7 like AHLTA, and I know you've probably been
8 briefed on ALHTA or will be briefed on ALHTA, our
9 electronic health records and some of the
10 challenges we face there as well as a bunch of
11 other programs. Some of these are ongoing, some
12 are successes, some are still works in progress
13 going forward.

14 Management activities. These are
15 headquarters activities, again, not a big account,
16 \$270 million. This is where we pay for all of the
17 headquarters functions. Education and training,
18 half a billion dollars, handles our HPSP and our
19 FAP programs, and pays for the university, Dr.
20 Rice's university up in Bethesda, so that's an
21 important account to us. We think that will grow
22 in time. We're looking at increasing

1 scholarships, I think you're all aware of that, in
2 trying to increase our ability to pay folks so
3 that they will be attracted to our service. And
4 base OPS is how we maintain our facilities. It's
5 built on some models going forward. The Walter
6 Reed situation back last year allowed us to put a
7 lot more emphasis on keeping our facilities up to
8 speed even though -- nothing to do with the Walter
9 Reed Hospital and everything to do with its
10 housing situation, it really did allow us to put a
11 spotlight on our facilities and get those things
12 up to speed. We're putting more money in there
13 and we're getting great support from the
14 department to do that and some military
15 construction as well.

16 I'll give you a little bit about MILCON.
17 This is what our program looks like in FY08. You
18 can see on the left-hand side the facilities that
19 we're going to be doing and the kinds of things
20 that we're going to be doing there. Although it's
21 releasable publicly in terms of the details, we
22 were able in the programming cycle for FY10 and

1 beyond to put some more money into MILCON. So
2 assuming it gets through all the various wickets,
3 we think we'll have some pretty good construction
4 projects going forward to really revamp some of
5 our very aging facilities. If you've been out to
6 some of our older places, as you know, we're
7 building a new Fort Belvoir under BRAC, but Fort
8 Belvoir is the second-oldest in the Army, not the
9 oldest, and there are others that are right behind
10 it.

11 In your material I think sent over to
12 Roger you should see a thing that looks like this.
13 It's a BRAC newsletter. We think that's
14 important. This is a document that we put out
15 that tells you about BRAC, what's going on in BRAC
16 both in San Antonio and in the National Capital
17 Area. We have a brand-new project officer there,
18 Colonel Sue Baker, who I've known for a number of
19 years. It gives you the timeline and our own
20 assessment of where we are, green or yellow, and
21 maybe red some day if we're not getting the job
22 done. But you can see what we're going to do in

1 the National Capital Area. We've had the
2 groundbreaking for Walter Reed with the president
3 and Fort Belvoir is under construction if you've
4 been out at Fort Belvoir recently out by, a big
5 crocodile tear, the golf course is no longer
6 there, by the main gate. It's a great facility.
7 San Antonio is doing the same thing. We're having
8 a great new clinic down there and a joint facility
9 with the Air Force and the Army down in San
10 Antonio.

11 This is an important account. This is
12 how we financed the retirees, the Medicare
13 eligibles. Most of those are over 65. But
14 essentially it's how we pay for the care going
15 forward and how it was done. It was established
16 in 2001. This is important, it recognized both
17 the accrued and the future liability of costs. It
18 didn't simply say we'll deal with it in the year
19 of execution. It actually began to think about it
20 differently. As the business panel gets to work,
21 this may be something that you might want to
22 consider for all retiree health care going

1 forward, to do it in an accrual fashion where
2 actually the liability is assumed in the future so
3 it's not lost on the Treasury. How it happens is
4 the Department of the Treasury when they
5 calculated the liability for retiree care it was
6 half a trillion dollars and despite our best
7 efforts we couldn't find anybody to write that
8 check. So what they decided to do was have the
9 Treasury put in about half a billion a year into
10 this account as an obligation of the taxpayer into
11 the account. Then each year when the military
12 people -- remember I mentioned that all people are
13 dollars in the out years? When the military
14 people buy -- military services buy their people,
15 attached to every one of those costs per officer
16 or per enlisted is a little bit of money that goes
17 into the account for their future liability for
18 health care so that the fund continues to grow
19 over time. Then the Treasury actually sells bonds
20 and things that we actually get interest off of.
21 All that goes that into the account. Then what we
22 pull out of that is based on an actuarial estimate

1 of how much workload it's going to be done that's
2 then reconciled against actual workload about 2
3 years later. So that's how it works and that's a
4 pretty creative way. This is actually how the
5 retiree account works in some respects. So it's a
6 pretty creative way in which we finance. We don't
7 do that for other people. We do that for our
8 Medicare eligibles. It's a pretty creative way
9 and I look forward to working with the business
10 panel on understanding that more for those of you
11 who would like to get into that.

12 Current financial issues. Obviously we
13 have a budget year execution for the wounded
14 warrior and wounded in transition. You all know
15 those situations. PH/TBI is a big issue for us.
16 How we baseline the -- just because the war ends
17 doesn't mean these young men and women who were
18 injured go away. We've got to find a way to
19 sustain that level of financing so we can sustain
20 that care for as long as they need it and we got
21 to get there. We're not there yet. We're working
22 on it. In MHS transformation, obviously our

1 electronic health records are an issue. We
2 continue to work with DOD/VA sharing. We want to
3 move to performance-based culture. That's my
4 value proposition with productivity, quality, and
5 customer satisfaction. We want to move in that
6 direction. We have a new entity named JMTFCAPMED
7 that's going to handle essentially Carlisle to
8 Quantico and everything in between. That's
9 standing up. We've got to find out financial ways
10 to give them the information they need to make
11 their leadership decisions. BRAC implementation I
12 mentioned on both San Antonio and National Capital
13 area, plus the collocation of headquarters. All
14 of the medical headquarters have to move together
15 some place. We have to figure that out and where
16 we're going to go with that. We have to do that
17 by 15 September 2011.

18 Then sustaining the benefit over time.
19 What are we going to do about the benefit? Are we
20 going to leave it the same? Are we going to try
21 to change it? Are we going to make modifications?
22 Look at the task force recommendations. Look at

1 the Quadrennial Compensation Review Commission.
2 Look at other alternatives going forward. We're
3 out of budget cycles to do it. We can't do it in
4 any current budget cycle. So the next
5 administration that comes in in January is really
6 going to have to deal with this and I think your
7 advice to that next administration whoever the ASD
8 is, whoever the PSAD is, whoever the DASDs are, is
9 going to be very important as well as to the
10 USDPNR, but most importantly to the services and
11 to the joint staff so that they get behind this
12 100 percent, either we all get behind this or we
13 just simply don't do it. And that's it. That's a
14 lot of slides and I apologize. Thank you.

15 DR. POLAND: It takes a lot of talent to
16 take something that complex and break it down into
17 understandable parts. I think we also have to
18 change that old saw to something more like a
19 billion here, a billion there, pretty soon it's
20 real money. Thank you for helping us to keep us
21 on time. I'm sure there will be a number of
22 questions here. Let me start with Dr. Silva.

1 DR. SILVA: Thank you. I agree. That
2 was a wonderful presentation. I think you've
3 stated the value what it's costing quite
4 accurately. It is a tremendous benefit that our
5 military gets. And compared to civilian rates as
6 a couple of the experts here know, this is pretty
7 cheap.

8 The one question I had is that the
9 military enjoys a large cadre of allied health
10 people. What percent of our outpatient visits are
11 seen by medics, corpsmen, nurse practitioners, et
12 cetera? The civilian community just doesn't have
13 that capability and that may be one of the reasons
14 you can offer care that is still relatively
15 inexpensive. So thank you for the presentation.

16 SECRETARY MIDDLETON: Thank you, sir.

17 DR. POLAND: Ms. Shinseki?

18 MS. SHINSEKI: A very quick question.
19 Thank you very much for your wonderful
20 presentation. Is it within your purview to assess
21 the reimbursement rate for TRICARE services among
22 the private sector? Because we are hearing from

1 beneficiaries that access to care may be
2 challenged because of that issue.

3 SECRETARY MIDDLETON: Yes. The Director
4 of the TRICARE Management Activity, Dr. Cassells,
5 has the authority to modify the reimbursement
6 rates. We are as you know by law tied almost
7 completely to the Medicare rates. Our rates are
8 tied to Medicare rates. For example, when
9 Medicare went through its issue a few weeks ago
10 with whether or not they were going to decrease
11 the reimbursement rates, we were right behind
12 them, and if they had, we would have. Fortunately
13 that didn't happen and smart people did smart
14 things. But we are tied to that.

15 We can increase those up to 15 percent,
16 but it has to be predicated on data. In other
17 words, it really has to be a fairly sophisticated
18 analysis of whether there is a true need to do
19 that because we get a lot of pressure. People
20 write in and say if you don't, I'm going to -- and
21 all those kinds of things. But we do have the
22 authority to do that, to actually increase the

1 rates above what we call TRICARE maximum allowable
2 charges, we can go above that, but it has to be
3 predicated. So yes, Dr. Cassells does have the
4 authority case by case to look at that.

5 DR. POLAND: Dr. Parkinson?

6 DR. PARKINSON: Full disclosure.
7 Colonel Middleton was my boss, so I learned
8 anything about economics from him years ago.
9 Stepping back a minute to the broader charge to
10 the Health Care Delivery Task Force, what you're
11 hearing is that the majority of care that DOD
12 acquires, they acquire it increasingly from
13 purchasing it from the civilian sector.

14 SECRETARY MIDDLETON: Seventy percent of
15 all the care we provide is purchased care.

16 DR. PARKINSON: That makes us the
17 biggest single purchaser absent Medicare in the
18 country of civilian health care. Just having
19 spent my last 7 years working with major
20 corporations, no one comes even close. The
21 department I would posit has not used its
22 purchasing power in innovative ways at a time when

1 literally you can go to meetings every week to
2 talk about the broken reimbursement system for the
3 way we reimburse physicians, physician assistants,
4 hospitals, and health care systems. So as you go
5 home and as you go back to these meetings, Ms.
6 Shinseki's point is spot on, if you have to go a
7 Medicare rate and you have an intermediary
8 contractor who nicks a few point off that rate,
9 you have an eroding primary care physician base in
10 this country with physicians rapidly leaving
11 practice and they give an option between taking a
12 TRICARE patient at 10 percent less or 3 percent
13 less or whatever and any administrative hassles,
14 guess what, I believe in patriotism, but we cannot
15 have an noncompetitive practice out there. So
16 with \$12 billion of purchasing power and with CMS
17 often times slow to innovate around innovative
18 payment mechanisms, I'll throw this out, what is
19 the role for us to think about? Not to comment on
20 now. But to think about innovative payment
21 mechanisms that combine wellness, prevention,
22 episode grouping, a baseline different way of

1 thinking? That's our opportunity here and what I
2 think Colonel Middleton is asking us for is the
3 leadership and creative thinking with this new
4 charge.

5 So it's a wonderful time. It's
6 absolutely appropriate that we go through those
7 buckets and learn the current practices while we
8 have the freedom to suggest alternatives in a way
9 that perhaps even guidance to CMS can't.

10 SECRETARY MIDDLETON: There is no
11 question about that. If there were a time when
12 the Defense Health Board could come forward and
13 make some strong suggestions, I think we're seeing
14 the convergence of lots of issues. We're seeing
15 the cost increases, we're seeing the war pressure,
16 frankly, the Walter Reed situation, all of these
17 are converging as enormous pressures on this
18 system and if ever there was a time for creative
19 thinking to think outside the box, Dr. Granger
20 right now is considering a pay for health care.
21 In other words, we would reduce your premium if
22 you could meet certain wellness standards, if you

1 are hypertensive and you control it, if you were
2 diabetic and controlled it. Where we are on that
3 and how we get there, we're going to need a lot of
4 thinking and we're going to need lots of
5 leadership. Frankly, there's only so much we can
6 push in the department, but this body with the
7 prestige of your position and your positions in
8 the civilian industry have an opportunity to
9 really help us push this down the road. So we're
10 looking for ideas. We're like (off mike) looking
11 for ideas. We're looking for good ideas. We're
12 looking for practical ideas of things we can
13 implement.

14 DR. POLAND: Dr. Lednar and then Dr.
15 Shamoo.

16 DR. LEDNAR: Just to follow-up on what
17 Dr. Parkinson was pursuing, DOD is a major
18 purchaser. When you look at the number of visits
19 and hospitalizations and health care utilization,
20 it's extraordinary. You've got an arrangement now
21 with three health plan vendors supporting the
22 three regions across the U.S. My question is,

1 have you looked at access to care to see that it's
2 adequate knowing that in certain specialties like
3 psychiatry, especially child psychiatry, it gets
4 pretty thin out there?

5 SECRETARY MIDDLETON: Yes.

6 DR. LEDNAR: And I'm also thinking about
7 the comment this morning that a portion of this
8 care is provided in rural, I'll call it medically
9 underserved areas of the country. With that
10 understanding, have you gone back to the three
11 health plan vendors and expected them to
12 strengthen their networks to better support DOD?

13 SECRETARY MIDDLETON: Absolutely. Yes,
14 sir. Absolutely. The access to care is a
15 critical component of the way in which they're
16 evaluated. That has a lot to do with how they do
17 their networks. How they do their networks says a
18 lot about how effective they are in their
19 negotiation with the providers to get the right
20 rates at the right places at the right time.
21 Rural areas are always going to be an issue for us
22 not -- good negotiation or good networks, but

1 because they're just not there. One of the things
2 we're seeing, and I have to brief this afternoon,
3 is a spotlight-stop light chart for the Under
4 Secretary of Defense and it's red. It's red
5 because we're seeing this jump since the beginning
6 of August of increasing costs in one service and
7 we think it's because, we don't have all the data
8 to look at, we're a little bit behind in the data,
9 because of the mental-health issue. We think it's
10 because what we're doing is we're finding
11 opportunities to buy health care downtown at more
12 cost than we can provide it because we don't have
13 the capability and the reason is because of
14 access. I think we finally turned the curve and
15 said it's not about cost. It's about getting
16 these young men and women care. When they come
17 back and they have psychological problems and they
18 issues, it's about getting them the care. It's
19 not about standing in line. It's not waiting for
20 a month. It's getting them the care, and if the
21 care is in the MTF, great, if the care is in the
22 network, okay, more expensive, but it's not about

1 how much it costs. So we're seeing this bump.
2 It's causing my unit costs to go up and that's why
3 I've got to brief on it. But access is part of
4 the evaluation process as is network development
5 for how we assess the contracts. And as you know,
6 we're in the procurement for the next generation
7 of contracts right now. It's underway today out
8 in the -- to procure the next series of contracts.
9 What's interesting is that we have brought to the
10 table a lot more vendors, a lot more people. We
11 used to have the same usual suspects. We've got a
12 lot more different new names on the table now
13 who've come on to bid on this. Now how it comes
14 out is beyond my ability to forecast, but it is
15 indeed absolutely part of the equation. I'd ask
16 General Kelly or Admiral Smith if they wanted to
17 comment on that as well. They're as close to this
18 as I am as far as the importance of access.

19 DR. POLAND: Let me go ahead and ask Dr.
20 Shamoo for last comment and then we need to break
21 for lunch.

22 DR. SHAMOO: Very small bookkeeping. Is

1 the \$44 billion part of the regular annual DOD
2 budget appropriation?

3 SECRETARY MIDDLETON: It is part of the
4 Defense top line, the total of the department's
5 budget, but it is -- much of it, not all of it,
6 not all \$44 billion because some of that is
7 people, some of those are dollars and people. But
8 the ONM procurement and research and development
9 funds that are received are received as a separate
10 appropriation.

11 DR. SHAMOO: Over and above the regular
12 DOD annual budget appropriation?

13 SECRETARY MIDDLETON: Right. I'll give
14 you an example of that for one second. In FY2007,
15 last fiscal year, the Department of Defense had an
16 appropriation. The Defense Health Program did not
17 have an appropriation. We went through the entire
18 year with a continuing resolution and ended up
19 with a joint resolution. We never had an
20 appropriation for FY07. The Department of Defense
21 did have an appropriation. So while we're counted
22 as part of the top line, it's a separate piece of

1 money. It can't be commingled.

2 REAR ADMIRAL SMITH: But when you hear
3 what the defense budget is, these dollars are
4 included in it.

5 SECRETARY MIDDLETON: In the defense
6 budget. Yes, sir.

7 DR. POLAND: Again thank you very much.

8 SECRETARY MIDDLETON: You're welcome.
9 Thank you.

10 DR. POLAND: We're going to break for
11 lunch now. Board members, distinguished guests
12 and speakers, lunch will be provided outside to
13 your left and all the way around where we had our
14 coffee break and breakfast. If we could, let the
15 new board members go through first. We'll take a
16 back table. I'd like to eat lunch with the new
17 board members and have a brief discussion.
18 Colonel Gibson, do you want to make a comment?

19 COLONEL GIBSON: For the rest of you,
20 there are a lot of places to eat outside this
21 hotel. Crystal City has a number of them
22 including part of the underground Crystal City

1 stuff. So we'll see you back at?

2 DR. POLAND: Right at 1:15 we'll start.

3 We're going to move one briefing scheduled for
4 tomorrow into this afternoon so we'll start right
5 at 1:15. Thank you.

6 (Whereupon, at 12:30 p.m., a
7 luncheon recess was taken.)

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

(1:23 p.m.)

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 DR. KIZER: Thank you, Dr. Poland.
2 There are no slides, so don't feel like you're
3 looking something in vain, and this will not take
4 15 minutes.

5 As the subcommittee we have met once,
6 our first meeting was just a few weeks ago. At
7 that meeting we had a lot of the obligatory
8 orientation that goes with these committees. I
9 agreed to serve as chair and Ray DuBois is the
10 vice chair. I think probably the most notable
11 thing from the purposes of this meeting is that we
12 did start discussing the issues. I think we were
13 convinced that there are some incredible
14 opportunities here and so we're anxious to get
15 more into the meat of the matter than we were at
16 that first meeting. We did identify three team
17 leads or at least as an initial infrastructure to
18 help guide our subsequent deliberations. Paul
19 Carleton was the team lead on looking at the
20 integrated health care delivery system. Nancy
21 Adams agreed to look at the work force realignment
22 issues. And Philip Tobey to look at the major

1 facility construction projects. With that we
2 charged Colonel Gibson and others with providing
3 some information for our next meeting at which
4 time we expect to actually start deliberating the
5 issues and getting more into the meat as I said.
6 With that I will be happy to hear your editorial
7 comments or try to respond to your questions or
8 not respond as may be more appropriate.

9 DR. POLAND: It's early on in this
10 effort, obviously, so are there any comments,
11 questions, points the board would like to make?
12 Dr. Wilensky?

13 DR. WILENSKY: Could you share a little
14 more if it's already been determined some of the
15 workforce issues that you think are likely to
16 dominate your discussions or Nancy's going
17 forward?

18 DR. KIZER: We tossed around some
19 things. We actually didn't focus that much on
20 workforce in this first discussion. We focused
21 more on what the assets were and what the current
22 relationships were, what future relationships

1 might be, and I think workforce is a subject that,
2 one, we needed a lot more information on before we
3 got into it, but it's something that will be dealt
4 with more down the road.

5 MR. DUBOIS: Gail, I think the
6 particular aspects of the workforce issues pertain
7 to the movement of civilian personnel of both
8 contractor and otherwise from Walter Reed Army
9 Medical Center to the new Walter Reed National
10 Military Medical Center. As you know, there have
11 been a number of comments mostly critical made of
12 what happened at Walter Reed with respect to the
13 civilian nonprofessional workforce and I will say
14 for the record that Congress didn't help us in
15 that regard when it came to contracting out the
16 nonprofessional aspects of support to the Walter
17 Reed Army Medical Center although I think we've
18 overcome some of that. But the movement to
19 Bethesda clearly presents some issues with respect
20 to the civilian workforce in particular.

21 DR. KIZER: Ray's comments obviously
22 reflect his particular knowledge and familiarity

1 with the issue. The committee itself has not had
2 an opportunity hear what all the issues are to
3 talk about them.

4 COLONEL GIBSON: Let me frame this just
5 a little bit. The first meeting that occurred was
6 primarily in orientation meeting. As you know, as
7 a federal advisory committee, members cannot start
8 to deliberate until they're fully appointed and
9 have filled out all the paperwork, et cetera.
10 That was one of the things we accomplished at this
11 meeting. Then got some baseline briefings from
12 Admiral Madison the Joint Task Force CAPMED on the
13 issues and started to develop a business plan
14 which will fill in in much, much more detail.
15 Admiral Madison pointed out something that I found
16 incredibly interesting. In their pursuit of how
17 to do this, they started looking for civilian
18 models on how to merge if you will a series of
19 health care providers in an area and they found
20 that there really is no model. When the major
21 health care providers in the United States come
22 into an area they just buy the hospitals, fire the

1 administrative and leadership staff and replace
2 them with their folks. That's not going to work
3 obviously for the Department of Defense in the
4 National Capital Region. So there's a lot of work
5 to do, and as I said, they're just getting
6 started.

7 DR. KIZER: The comment I would make
8 here and I didn't belabor it during the meeting
9 was that while there may not be many good civilian
10 models, there is a very large experience in both
11 local facility integration and network creation
12 and integration in the VA and that is an
13 experience that needs to be looked at much more
14 closely than was done.

15 DR. POLAND: New members of the board
16 will begin to see the way in which the meeting
17 moves along. I'm going to now give three updates
18 and this is true of all the different task forces,
19 subcommittees, et cetera. As they do their at our
20 meetings, they'll provide updates as to what
21 they're doing and answer questions. I am going to
22 move the Deployment Health Research Center

1 external review forward to today and we may move
2 one other presentation potentially forward. I
3 don't know if I should take something like this
4 from a Special Forces guy. It's the other end.
5 I'm going to give a brief update on the Vaccine
6 Safety and Effectiveness Working Group report.
7 You'll recall that DOD had requested that we form
8 a work group that had these objectives associated
9 with them, to look at DOD postlicensure vaccine
10 safety, effectiveness, and surveillance studies;
11 review and discuss the published and more
12 importantly unpublished data with regard to DOD
13 vaccine research; discuss future vaccine safety,
14 effectiveness, and surveillance studies. Note
15 that the focus is entirely on FDA-approved
16 vaccines, so we weren't looking at experimental or
17 not yet licensed vaccines. And really what this
18 work group was to do was to provide guidance and
19 advice on what studies should be done, what the
20 priorities would be, and identify research gaps
21 research gaps in areas that we thought needed
22 further development.

1 We've had just the first meeting. DHB
2 attendees included myself, Dr. Kaplan, Dr. Silva,
3 Dr. Miller, and Dr. Walker. We met at USIS in
4 the very beginning of June. We received briefings
5 from Colonel Randy Anderson who was then heading
6 up MILVAX, Dr. Tyler Smith from the Defense Health
7 Research Center, Colonel Phil Pitman, Angela Eick,
8 Commander Kevin Russell from NHRC, and Colonel
9 Renata Engler from Walter Reed through the VHCs.
10 It's maybe a little hard to read on some of this.
11 Is this the right slide set? That should be red.
12 I just used a format of red, yellow, and green,
13 green meaning that they had met certain
14 objectives, yellow meaning that they had achieved
15 some of them, and red meaning there had been
16 little or no progress.

17 Specific issues that we identified and
18 will further talk about were the need for enhanced
19 interactions, coordination, and collaborative
20 efforts across DOD with regard to vaccine
21 surveillance. It's still the case that you can't
22 necessarily, and I've had personal experience with

1 this, try to understand for example influenza
2 immunization rates. It turns out that things that
3 are done on board ship don't necessarily make it
4 to the granddaddy of databases, et cetera; the
5 need for external validation of vaccine research
6 initiatives. In particular, most of our meeting
7 was spent not surprisingly talking about anthrax
8 and smallpox and to some degree influenza vaccine,
9 much of this driven by vaccine recipient concern
10 over long- term safety, potential reproductive
11 health effects, hospitalization rates, et cetera.
12 And this issue of reproductive health really did
13 stand out as an important issue in terms of
14 research initiatives.

15 We did talk about the ACAM 2000 vaccine
16 which is being stockpiled and the coming though
17 not yet -- has adenovirus vaccine been licensed?
18 Not yet. We also reviewed this group in its
19 former iteration called the AFEB, the Infectious
20 Disease Subcommittee and at the time I happened to
21 chair that, did what was called a DOD-wide review
22 of vaccine policy and procedures. I bring it up

1 because we had multiple meetings over more than a
2 year. We had an outside contractor and some
3 significant money to really dig into this. This
4 resulted in a published monograph and series of 12
5 recommendations that I'll take you very quickly
6 through unless questions come up.

7 One, that policies and practice ensure
8 the ready supply to the military of vaccines
9 essential to the mission be developed. And we
10 indicated that there had been a lot of progress in
11 terms of MILVAX and Health Affairs monitoring the
12 supply situation and engaging other DOD entities
13 as needed, that the adenovirus vaccine project was
14 funded and well underway. As members of the board
15 know, there have been repeated delays in that
16 subsequently. But we did comment that new vaccine
17 development was inadequately funded and slow, and
18 we had made the recommendation about thinking more
19 about a DOD-owned manufacturing facility and that
20 had not been implemented beyond the rare pilot
21 plan.

22 Recommendation two was that DOD further

1 develop and expand efforts toward standardized
2 computerized recordkeeping and tracking of all
3 administered vaccines to all persons including the
4 ability to rapidly access that information and to
5 standardize that not only across services but
6 across the different types of facilities that were
7 used. Substantial progress had been made in that
8 regard. We did note some areas for work that
9 needed to be done. I mentioned the Navy shipboard
10 system and the synchronization efforts, the
11 ability to track family members and retirees, the
12 ability to exchange electronic immunization
13 records, and to give retirees and separate
14 personnel access to their immunization records
15 which as you might imagine is an issue when they
16 then go into the civilian health sector.

17 Recommendation three was that each
18 service measure and report up-to-date immunization
19 rates as really key indicators of medical care
20 delivery and force readiness. We indicated that
21 some progress had been made here. Immunization
22 rates as indicators of troop readiness were for

1 the most part available and tracked, but there
2 still needed to be work on immunization rates of
3 communities based on age or underlying risk
4 factors that would call for a certain vaccine.

5 Recommendation four was that they
6 consider the concept, and at the time we
7 articulated it as a Vaccine and Immunobiologics
8 Oversight Board, and in particular, remember this
9 was 1999, that there be increased involvement of
10 Reserves and National Guard in the planning and
11 implementation of immunization programs. We felt
12 this one had been achieved, and in particular,
13 MILVAX had performed an admiral job in
14 synchronizing and coordinating programs among the
15 armed services to include the Active Reserve and
16 Guard components. And as you all know as we have
17 traveled together through anthrax and smallpox,
18 they did just a superlative job in managing those
19 programs.

20 Recommendation five was to develop and
21 disseminate a joint instruction and in particular
22 address issues regarding IND vaccines, a policy

1 for introducing new vaccines, how informed consent
2 would be obtained, how we would revise
3 recordkeeping requirements, reduce differences
4 between services, and an increasing issue as the
5 next cohort gets to the age of enlistment or
6 enrollment into the military where they are often
7 well immunized and do we really need to spend
8 money overimmunizing them, if you will. Again,
9 that had been achieved. A new joint instruction
10 was developed and was disseminated in 2006 and we
11 thought that in particular the Air Force and the
12 Army had done an excellent job of screening basic
13 trainees for preexisting immunity to these
14 vaccine-preventable diseases and that the Navy and
15 Marine Corps, we were less sure about the Coast
16 Guard because I don't think we had a Coast Guard
17 rep there at the time, needed to catch up in that
18 regard.

19 Recommendation six was to look at
20 whether current procedures and resources were
21 sufficient to ensure appropriate personnel were
22 aware of current official policy. As we went

1 through that process, it became obvious that as
2 people rotated through various tours, they might
3 have an old joint instruction, they might be
4 unaware of new changes, and that had clear impact
5 on what was or was not done. Again we thought
6 that substantial progress had been made here
7 primarily due to MILVAX. But there was still some
8 ongoing, as will always be the case, efforts to
9 educate providers, medics, troops, and other
10 beneficiaries and families.

11 We also recommended that DOD commit to
12 fully informing every service member of the health
13 risks, personal and military benefits, and proper
14 use of all vaccines and other countermeasures, in
15 particular risk- communication materials, VIS
16 statements, off-label use policies, and
17 risk-communication research. Again I can only
18 give the highest commendation possible to MILVAX,
19 and at the time, Colonel Grabenstein who really
20 did a bang-up job in doing this.

21 Recommendation eight was to address the
22 issue of standardized training and proficiency of

1 immunization delivery practice, and again I'll
2 just say that Immunization University here we
3 thought was a very novel and creative effort to do
4 this. In fact, they had set the bar now and
5 civilian entities are trying to catch up in that
6 regard. We did think -- and again this will be
7 ongoing because the pool keeps changing, expand
8 the training the effort to reach all immunizers
9 and adopt and enforce explicit criteria for
10 training.

11 Nine was to develop a vaccine policy and
12 practice statement for the use of vaccines in
13 humanitarian issues. So we were a little bit
14 ahead of the curve in 1998 and 1999 as we looked
15 at this. Just to tell you a bit of an anecdotal
16 story, in my father's first tour in Vietnam, they
17 went through one area, brought Navy medics with
18 them and provided at the time smallpox and polio
19 immunization in a village and it was not too long
20 afterward that the NVA came through and identified
21 everybody who had an immunization mark and
22 amputated their arm. So it's just one of the many

1 kinds of issues, that being pretty dramatic, of
2 how we have to think through how we might use
3 vaccines particularly if there's a schedule
4 associated with them in humanitarian missions, and
5 that's an ongoing issue that will be dealt with by
6 another subcommittee.

7 Number 10, maintaining the current
8 centralized procurement system while providing
9 flexibility at the local level. Again, we thought
10 that a lot of progress had been made in that
11 regard.

12 Eleven, that DOD continue to participate
13 in the development of a comprehensive pandemic
14 influenza planning document. Again, we were
15 pretty ahead of the curve when I look at this in
16 retrospect. And devise, disseminate, and test a
17 DOD-wide plan. Again, substantial progress has
18 been made there and there is now a Select
19 Subcommittee on Pandemic Influenza.

20 Then lastly, that there be a review of
21 vaccine policy, practice, and use recommendations
22 every 2 to 3 years. We made the point that since

1 the last joint instruction came out in 2006, now
2 is an appropriate time to do that, but that's
3 pretty much the cycle anyway and they're on course
4 for that.

5 So our overall assessment, we gave them
6 a letter grade that DOD deserved a letter grade of
7 A for all the work that had gone into this. They
8 had made substantial practice in virtually all
9 areas identified in 1999. We did see a few more
10 opportunities and that is to further enhance the
11 electronic immunization tracking system, develop a
12 humanitarian and stability vaccine policy, ensure
13 the availability of all vaccines, the poster child
14 for this being adenovirus, and that they maybe
15 more formally incorporate the great work that they
16 had done in training by engaging in something like
17 vaccinator certification.

18 Next steps, we anticipate another two to
19 three meetings. This first meeting was
20 introductory primarily for us to get briefings and
21 hear about what was going on and hear about
22 unpublished research that we hadn't had access to.

1 The next steps I think will be that we will have
2 some meetings focused around particular vaccines
3 that have been proximate stimuli, if you will, for
4 a lot of this work, and those would include
5 anthrax and smallpox. And the larger agenda being
6 this overall coordination and management of
7 vaccine surveillance efforts.

8 I will stop there on this point and
9 entertain any questions or comments you might
10 have.

11 DR. OXMAN: I know this focus has been
12 on FDA- approved and licensed vaccines, but there
13 are some situations that are unique to the
14 military, and adenovirus is a good example where
15 there may never be a large enough general public
16 interest to stimulate the development of vaccines
17 that would be used widely and FDA licensed.

18 DR. POLAND: Just to check in with you
19 here, Mike, the adenovirus vaccine will be
20 licensed before it's used.

21 DR. OXMAN: I understand that. That's
22 adenovirus and 7, is it?

1 DR. POLAND: Four and seven.

2 DR. OXMAN: Four and seven, common
3 adenoviruses. But not dealing with new
4 adenoviruses.

5 DR. POLAND: So your point is really
6 about IND- level vaccines?

7 DR. OXMAN: Right, and I think if the
8 military doesn't stimulate interest and investment
9 in that, nobody else will.

10 DR. POLAND: I think that's a fair
11 point. Hemorrhagic fever vaccines would be
12 another example. There are mechanisms by which
13 those vaccines can be used under emergency
14 authorization or under the order of the president.
15 Those are difficult to today's world. They've not
16 yet proven necessary. But I think your point is a
17 good one both in terms of how do you stimulate if
18 you will orphan vaccine development, and then how
19 do you use those. Mike Parkinson I think had a
20 question, and then Dr. Blazer.

21 DR. PARKINSON: Thank you for the
22 update. I would agree that it's an A. I think

1 it's fantastic. But I ask myself as we're going
2 through the 12 recommendations what environmental
3 factors or forces are now emergent in this area
4 that weren't there 10 years ago? There are at
5 least a couple as you go forward to think about.
6 One is there was an area where you noted some
7 improvement could be made and that is in the
8 layperson's knowledge, beliefs, and attitudes
9 about vaccination. If anything, as you know
10 better than anybody, we've lost ground. We're
11 having outbreaks of vaccine-preventable disease.
12 We have spotty exemption policies all around the
13 country. I dare say that they might be a little
14 different as to the way they're implemented. They
15 might read the same in policy, but the way they're
16 implemented across DOD in terms of exemptions to
17 vaccination. And now that we're using more and
18 more Guard and Reserve where we even have less
19 day-to-day control perhaps over the knowledge and
20 attitude than the traditional active duty, that's
21 certainly an area that we should look at.

22 The other whole thing that I've

1 appreciated as someone who is a preventive
2 medicine officer, our whole awareness of the
3 epidemiology and the utility of things like
4 nonvaccine approaches to control disease,
5 isolation, containment, personal hygiene. All of
6 those things which are disease-control measures
7 which are not the administration of the shot.

8 DR. POLAND: Good point.

9 DR. PARKINSON: Also the science has
10 advanced tremendously or at least the awareness
11 over the last decade. So as you go forward maybe
12 you can put those in your consideration for the
13 committee.

14 DR. POLAND: Good points. Thank you,
15 Mike. Dr. Blazer?

16 DR. BLAZER: Thank you for that update
17 and I look forward to learning a lot from you
18 about the development of vaccines and
19 administration in a military setting.

20 DR. POLAND: Fascinating topic,
21 actually.

22 DR. BLAZER: I do have a question about

1 how you foresee your working group interfacing as
2 response are made to these recommendations
3 vis-à-vis protection of human research subjects,
4 the autonomy question, the informed consent that
5 was already mentioned, how that might be monitored
6 or evaluated.

7 DR. POLAND: That's a very good
8 question. It's very complex with a lot of nuances
9 and we're going to need help in that regard in
10 terms of advice or recommendations that we would
11 make. I recognize that for most of these vaccines
12 at least in the active-duty forces, they are
13 mandatory vaccines so they get the vaccines.
14 Where it becomes an issue is when there is
15 controversy around the vaccine or the set of
16 vaccines, things like anthrax vaccine, autism and
17 MMR vaccine, overloading the immune system with
18 multiple vaccines, et cetera. Those get harder,
19 and reproductive health, because there you have a
20 concern -- I'm not saying that there's evidence to
21 support this, but there you have a concern where a
22 service member gets a vaccine and the concern of

1 the family is on their children or the
2 reproductive health of their spouse. So the
3 spouse or child hasn't consented if you will to
4 that vaccine and yet voices concern that they
5 could somehow be harmed by those vaccines.
6 There's a lot of nuance there.

7 DR. BLAZER: I would welcome being
8 involved in that conversation. Thanks.

9 COLONEL GIBSON: I just want to be clear
10 on the question of human subjects. The vaccines
11 used by the Department of Defense are FDA-approved
12 vaccines.

13 DR. POLAND: They're licensed.

14 COLONEL GIBSON: Even with this issue
15 with adenovirus vaccine, while we established
16 CRADAs to help develop the vaccine, it went
17 through and is going through exactly the same
18 phase one, phase two, phase three types of studies
19 as is every other vaccine that's available through
20 FDA licensure. So we're not talking about DOD
21 doing something internally with respect to
22 development of vaccine or giving it to service

1 members outside of an FDA-approved product.

2 DR. POLAND: That needs to be stressed,
3 yes. Ed?

4 DR. KAPLAN: This is a DOD issue, no
5 question about it. But you mentioned the issues
6 with concern about children getting vaccines and
7 even though this is a DOD issue, I'd like to
8 remind the board that there were actually, and I
9 don't know whether they're scheduled in the
10 future, congressional hearings which didn't
11 exactly promote the use of vaccines particularly
12 in children. Is there some kind of discussion
13 that could take place or could this board provide
14 advice and not on one side or another, but just
15 open a forum for being able to discuss this issue?

16 DR. POLAND: I'm just looking over at
17 some of the MILVAX folks to ask if you want to
18 make any comment about that because I know you're
19 sensitive to those issues and trying to address
20 them.

21 LIEUTENANT COLONEL GARMAN: Sponsored by
22 the Department of Health and Human Services they

1 have started a national task force just on
2 immunizations. It's a government-wide task force
3 and DOD has been part of that and it focuses on a
4 few main areas. One of them is vaccine safety and
5 another one is risk communications. So it's at a
6 national level and it's trying to develop the
7 tools to effectively communicate and to set a
8 research agenda with agencies like NIH, DOD, as
9 far as vaccine safety.

10 DR. KAPLAN: This sounds like two ships
11 going along in a parallel track. Is it
12 appropriate to have some kind of liaison or
13 communication back and forth or is it an entirely
14 different issue?

15 LIEUTENANT COLONEL GARMAN: Sitting in
16 on the task force, I think it's entirely
17 appropriate. It's being managed by the National
18 Vaccine Office up at the headquarters of HHS and
19 I'm certain that they wouldn't mind briefing this
20 board on their progress.

21 DR. POLAND: NIH just released another
22 set of vaccine safety RFAs.

1 DR. KAPLAN: But if I just may make a
2 comment, they're going along making these and I
3 understand that and we're going along doing what
4 we're doing and there's a considerable amount of
5 overlap, and whether this is redundancy or for a
6 different purpose I don't know, but it seems to me
7 that just as we've tried to make contact with
8 other groups with regard to pandemic influenza and
9 one thing or another --

10 DR. POLAND: That might actually be a
11 good example. In this case the questions and
12 controversies that come up have to be informed by
13 science and so DOD may do some of that, but a lot
14 of it's going to be done in the civilian sector
15 because of the numbers needed. So that science
16 gets done, disseminated, and then gets translated
17 into how do we educate and how does that inform
18 policy and doctrine. Did I answer your question?

19 DR. KAPLAN: Yes, I think so. I guess
20 the theme that keeps coming up is duplication and
21 I don't think it's our role to usurp any of the
22 tasks that this other group is going -- nor are

1 they ours, but it seems that there should be some
2 kind of communication since we're talking about
3 the same things. Roger, is that a crazy idea?

4 COLONEL GIBSON: Yes.

5 DR. KAPLAN: I'm not going to buy you a
6 drink tonight, Dr. Gibson.

7 COLONEL GIBSON: The charge of this
8 board as a federal advisory committee is all
9 things health for DOD. Consequently, the issues
10 of childhood immunizations for DOD beneficiaries
11 is part of your charge. You're limited to DOD
12 beneficiaries. This board has in the past as well
13 as taken questions and issues from the department
14 has asked questions of the department. Is it
15 possible for you to interface with other agencies
16 that are looking more broad scope than just DOD?
17 Certainly, and we could set that up as we go
18 forward. Is this is something that the board as a
19 whole is interested in, then we could pursue that.

20 DR. POLAND: Ed, if you can help
21 remember, we'll come back to that and address that
22 at our next subcommittee meeting. Pierce?

1 DR. GARDNER: I think the 1999 committee
2 should be very proud of its deliberations and very
3 pleased.

4 DR. POLAND: We were.

5 DR. GARDNER: Ten years later much has
6 happened and I congratulate the Chairman of both.
7 But I would follow-up on Mike Parkinson's
8 comments. It seems to me the thing that's truly
9 changed in the last decade is the voices of
10 antivaccination community have become increasingly
11 loud without really any serious data to back it
12 up. I don't worry at all about redundancy or
13 duplication. The military again has the ability
14 as were talking about earlier today to publish its
15 experience with vaccinations and adverse reactions
16 and it seems to me that's an important function
17 for us to say when nothing bad has happened
18 because the internet sends rumors and
19 misinformation and we have not really figured out
20 an effective way to blunt that. In fact, that
21 we're having to answer all these defensive things
22 suggests that. I would say that the

1 recommendations are great but we should have some
2 organ or some way to publicize it that life is
3 good and not everything is in danger.

4 DR. POLAND: That's a good point and the
5 both military and civilian sectors are struggling
6 with that issue.

7 I'm going to move on to the next brief.
8 I'll now give an update on the biowarfare
9 countermeasures. You'll recall that there is a
10 DOD directive called the DOD Immunization Program
11 for Biologic Warfare Defense where we are tasked
12 with providing the ASD for Health Affairs with
13 advice and recommendations regarding biological
14 warfare countermeasures and that includes
15 research, acquisition, and execution. The task
16 force members who intended this included Dr.
17 Kaplan, Dr. Silva, Dr. Oxman, myself, and Dr.
18 Gardner, and there were a few background things
19 you should know about. One was an April 10
20 meeting where we heard from DTRA and Force Health
21 Protection and Readiness and we as Medical
22 Logistics, another meeting that occurred April 23

1 through 24 with MILVAX and representatives from
2 the Vaccine Healthcare Centers, and then finally a
3 meeting July 11 that we just had where we heard
4 briefings from DIA and DARPA.

5 In terms of the update from DARPA, and I
6 can only give generalities because these were
7 classified briefings and this is an open meeting,
8 we felt that there was a significant and
9 impressive science base that was going on that was
10 pretty far forward looking in the chemical,
11 radiologic, and nuclear areas.

12 In terms of the Chairman's threat list,
13 we noticed a movement toward something we had been
14 advocating for over the years and that was a
15 matrix-type list that incorporated the
16 intelligence, the capability, the intent, and how
17 things might be changing over time, so we were
18 happy to see a somewhat different format of matrix
19 rather than just we think country X has this

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 threat or doesn't.

2 So our overall assessment, and I realize
3 this is general is, but it's the nature of how we
4 have to be in an open meeting, we had some concern
5 with current activity in the biologic science
6 space within DARPA. There were concerns about the
7 timeliness of the Chairman's threat list updates.
8 We're supposed to get them yearly and then comment
9 back in memo form yearly on what those
10 countermeasures should be, and there have been
11 delays in that. The overall result will be that
12 the Infectious Disease Control Subcommittee will
13 write new biowarfare countermeasure
14 recommendations. Questions?

15 DR. MILLER: Greg, can you comment a bit
16 about the role of BARDA, the HHS component, and
17 how that relates to DARPA, not to much duplication
18 of functions, but complementary aspects?

19 DR. POLAND: Actually, Mark, that's a
20 good point and I'm a bit embarrassed to say that
21 that didn't come up in the discussions and should
22 have. Given the recent standing up of BARDA and

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 the amount of dollars they've received, there
2 really was not much discussion about that.

3 DR. JAMES: In conjunction with that and
4 the previous conversation, I've been involved with
5 a lot of meetings involving BARDA, HHS, Homeland
6 Security, and right now there's an awful lot of
7 interest and activity specifically in the anthrax
8 threat. In looking at that, they're looking at a
9 med kit solution where they put Cipro or
10 doxycycline in every home in the nation. What's
11 not informed is the whole anthrax vaccine
12 approach, and when you try to introduce it, it's
13 obvious that there is a reluctance to go anywhere
14 where immunization is a countermeasure, part one,
15 but part two, there really isn't any DOD informing
16 based on their experiences with the vaccine, et
17 cetera, over time. It's an area where the
18 government is still in three parts divided.

19 DR. POLAND: And I might also say too
20 that there are appropriate differences between
21 what BARDA does and funds and what DARPA does and
22 funds and our concern was with the kinds of

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 activities that have to be funded now to have a
2 product that might transition into something
3 BARDA-like 10 or 15 years from now. Pierce?

4 DR. GARDNER: Stop me if I say something
5 that's beyond what we should talk about, but it
6 seems to me we were repeatedly told about the
7 shortcomings or limitations of surveillance for
8 all the bioterrorism. I don't think that's off
9 limits to say. And we focused I thought more on
10 some of the issues of the potential for various
11 pathogens to be manipulated to become bioterrorism
12 agents particularly as we're now in our Unibomber
13 type or mad scientist type of threat as well as
14 the national lab of an evil empire country. So I
15 thought we had put something on the table to
16 suggest more attention not to necessarily what we
17 know is a threat, but to what could potentially be
18 used to become a threat.

19 DR. POLAND: You're exactly right,
20 Pierce, and I alluded to it by just saying
21 concerns over the biologic. I guess what we can
22 say is there was some discussion about the

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 so-called black biology, for example, the ability
2 to manipulate anthrax or smallpox strains to be
3 vaccine resistant or other such things.

4 DR. GARDNER: Or influenza.

5 DR. POLAND: Those are the kinds of
6 activities that are likely to be funded at DARPA
7 and not likely to be funded by any other
8 nonmilitary sort of funding agency. So those are
9 the things we have to be looking at now for the
10 threats of the future.

11 DR. HALPERIN: Was the charge to DHB
12 limited to the infectious or did it include the
13 chemical? Is it just the biologic?

14 COLONEL GIBSON: The DOD directive that
15 charges the board with this responsibility
16 addresses biological. That said, there's nothing
17 precluding the Department of Defense in engaging
18 in discussions regarding chemical issues as well.
19 And we have an Occupational and Environmental
20 Health Subcommittee that has the type of
21 toxicologic background and expertise to engage in
22 if we so desire.

 ANDERSON COURT REPORTING
 706 Duke Street, Suite 100
 Alexandria, VA 22314
 Phone (703) 519-7180 Fax (703) 519-7190

1 DR. POLAND: So Bill, there's the
2 specific directive, so it's biologic and in
3 particular the vaccine aspect of it.

4 DR. PARKINSON: At the risk of putting
5 work on our colleagues or institutions, I wonder
6 of this topic now going on 7 or 8 years post-9/11
7 wouldn't be politically or even outcome-wise best
8 handled through bringing together an IOM process
9 with a fresh review of what were the risks, what
10 we've done, where we've integrated, where we've
11 not. It seems like it's bigger than any one group
12 to pull together. I don't know, it's something to
13 think about offline a little bit, is it a time to
14 take another gut check in a cross-national,
15 international way almost, what was our intent, are
16 we on target, things to do. Sometimes IOM studies
17 help in that regard, you need a sponsor or you
18 need some money, but just something to throw out
19 in the mix as I listen to the dialogue today.

20 DR. POLAND: Perhaps particularly when
21 you think about how do you develop an actionable
22 threat matrix, and it's the classic dilemma, what

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 do you do with constrained resources in a
2 low-probability but high-consequence sort of
3 scenario? It's difficult.

4 DR. LEDNAR: I had a similar thought to
5 Mike. Maybe it's a homeland security sort of a
6 thought process, but in terms of biological
7 warfare preparation and defense, some of it's
8 relying on our intelligence-gathering capability,
9 we've got funding throughout governmental agencies
10 in bits and pieces. Is there anybody in the
11 United States who knows everything that is being
12 funded by taxpayer money in this area so that we
13 have the best part of the government or private
14 sector working on it in a way that comes together
15 as a package for national security?

16 DR. POLAND: I know the answer to that
17 is above my pay grade and security classification.

18 DR. JAMES: I help answer that though,
19 the HHS Science Board, one of their subcommittees
20 is working on accumulating just that packet of
21 information.

22 DR. POLAND: And DSB does some of that

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 too, but your point is sort of like who's the
2 point person. Good point.

3 I'm going to move on to the last one
4 which I don't see up here. The last one I'll tell
5 you about is something we just concluded last week
6 I guess it was.

7 COLONEL GIBSON: Dr. Poland, the slides
8 are in Tab 12.

9 DR. POLAND: Thank you. And that is an
10 external review of the Defense Health Research
11 Center. Attendees included myself, Dr. Lednar,
12 Dr. Oxman, Dr. Silva, Dr. Kaplan, and Dr.
13 Halperin. Our task was to provide an external
14 review of the Defense Health Research Center in
15 San Diego. As I said, we just finished this last
16 week, or I should say started it might be a better
17 way to say it. In 1999 there was a National
18 Defense Authorization Act that directed the
19 Secretary of Defense to establish a center devoted
20 to the idea of a longitudinal study, key operative
21 word there, longitudinal study, to evaluate data
22 on the health conditions of members of the armed

 ANDERSON COURT REPORTING
 706 Duke Street, Suite 100
 Alexandria, VA 22314
 Phone (703) 519-7180 Fax (703) 519-7190

1 forces, and the focus then happened to be upon
2 their return from deployment. That got
3 incorporated into policy which was to conduct
4 epidemiologic studies to investigate findings from
5 surveillance and clinical data, support inquiries
6 from senior policy officials, and to monitor
7 postdeployment health of military populations.
8 There would be collaboration with other federal
9 and nonfederal agencies in conducting these
10 longitudinal epidemiologic studies, and there was
11 a list there of who that might be, and that all
12 epidemiologic research would be managed by unique
13 protocol and external scientific review.

14 Our members went there. We spent about
15 two- thirds of a day or so with the team out there
16 and heard a number of briefings, it have been 15
17 or so, sort of rapid- fire, that was designed to
18 give us a taste, a flavor, an overview of what was
19 going on. From that we have some draft
20 recommendations that we'd like to move forward on
21 and bring to the board, and I'll just tell you
22 some of those.

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 One, and I want to thank Dr. Lednar who
2 also helped articulate some of what you're going
3 to see on these slides, was in the governance and
4 research-management aspect. We thought that DHRC
5 would benefit from a high- level triage system for
6 peer-reviewed vetting of all of the research that
7 they undertake. We had the sense, and this is
8 observational and not so much critical, that there
9 was a hodgepodge of different types of studies
10 that might arise from a variety of areas sometimes
11 based on researchers' interests rather than
12 necessarily following a map of priorities. We
13 also thought that a research administrative
14 structure should be enhanced and in place for
15 things like communicating deadlines and RFAs and
16 disseminating and communicating findings to other
17 sister DOD entities.

18 We strongly felt the need for a
19 big-picture thread of what studies needed to be
20 done and what priority and with what resources.
21 For example, we might hear a study as we did about
22 the role of combat and its association with

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 hypertension, some smoking studies, which are
2 important but probably if each of us had to look
3 at postdeployment troops and longitudinal health,
4 those might not be in our top five or 10 or even
5 15 studies that should be done.

6 Recommendation two was that there be a
7 research career-development track. It was our
8 impression that while it was a very energetic and
9 productive team, it was a young team and there was
10 a lot of changeover that had occurred. And we
11 noted that previous leadership success, the
12 previous three leaders of this, we noted some
13 common attributes. They were physician
14 epidemiologists with the corresponding skill set
15 and clinical insights, they were senior-level
16 career military officers, and they had external
17 research credibility, that is, they had published
18 in the peer- reviewed journals, they had often
19 gotten peer-reviewed federal grants, et cetera.
20 And this would translate into the need for stable
21 funding, a career ladder, the senior leadership
22 skill set that I mentioned, mentoring, and further

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 development of graduate program linkages to
2 enhance the productivity and capability of the
3 unit.

4 Recommendation number three was mission
5 scope and opportunities, and that really needed to
6 be defined. As you could see from the first slide
7 I showed you where it's supposed to be
8 postdeployment longitudinal studies or inquiries
9 from senior public -- it soon leads to the sense
10 of they're trying to be everything to everybody
11 and we may have to better define that particularly
12 when you get to the idea that there are concerns
13 about long-term effects, acute exposures,
14 reproductive and dependent health, it's really the
15 entire breadth of health-related issues. Funding
16 and staff were further issues that we thought
17 needed to be better defined.

18 Recommendation four was the opportunity
19 to move from hypothesis generating to hypothesis
20 testing. For the most part, at least the studies
21 that we heard about, were cross-sectional and
22 longitudinal cohort studies that I think served

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 the very important role of generating importance
2 hypotheses and providing some initial information,
3 but how would these findings either be validated
4 in clinical studies or translated into clinical
5 studies and in turn new policies and doctrine?

6 Then corresponding with this is the
7 research-to- practice idea, that research relevant
8 to military concerns had to be the first
9 priorities and the findings had to be incorporated
10 into an informed, in some cases service- specific
11 and DOD-relevant doctrine and policy. It was
12 impression, and I'll leave it at that level of
13 word, impression, we were only there two-thirds of
14 a day, was that it was not clear that this occurs
15 or if it did occur what that process might be.

16 Recommendation six was linkages within
17 DOD. Again, we had the impression from the 15 or
18 so studies that we heard about that there were not
19 strong linkages with other DOD assets that could
20 significantly and materially improve the science.
21 For example, there were not strong linkages with
22 the DOD Serum Repository or other DOD databases

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 that would allow not only for stronger science but
2 in some cases to test the hypotheses that had been
3 generated. Of course, we felt that there was a
4 role for further DHB involvement. Let me just say
5 in the strongest terms possible that this
6 millennium cohort study, and I know I have not
7 gone into a lot of detail about that, but we could
8 answer some questions in the question-and-answer
9 session, offered a singularly important and vital
10 asset to DOD and the nation. This is on the line
11 of something like the Framingham Study or the
12 Women's Health Study. This is unlikely to be
13 funded or duplicated in any other venue, and while
14 this involves military members, something unique
15 about this and almost undoable in the civilian
16 sector was the number of women, minorities, other
17 ethnicities, that could be studied. It was a
18 cross-section of America that couldn't be done
19 probably any other way or at least not as
20 efficiently as it could be done here. As such it
21 offers or really has the potential to offer
22 profound insights into health and the health

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 experience. We felt that an additional in-depth
2 visit would be invaluable in assisting the Defense
3 Health Research Center in its mission and in
4 providing the level of outside expert review and
5 support that we think they need and deserve.

6 The overall assessment was that DHRC and
7 the millennium cohort study were unparalleled
8 national treasures is the way we really
9 articulated it. They were a highly dedicated team
10 with a successful history. We sensed aspects of
11 mission creep, lack of a career ladder, not as
12 stable material support, all of which threatened
13 to erode the value and effectiveness of this
14 asset, and we thought that there were members of
15 DHB who would have something to offer in terms of
16 recommendations and expertise. So I'll stop there
17 and ask first for any comments from any of the
18 members who were there. Wayne?

19 DR. LEDNAR: I'd like to go back to one
20 of the very first points that Dr. Poland made and
21 was that this is a longitudinal cohort. Dr.
22 Kaplan in particular I think has brought to our

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 attention that as we think about what a
2 longitudinal cohort can tell us about and as we
3 try to respond to the questions on today's agenda,
4 we have the capability to answer questions that
5 will only first emerge in the year 2020. And if
6 we are able to mentally to fast- forward and put
7 ourselves in 2020, what questions would we have
8 that this cohort could be perhaps the only way to
9 answer? With that in mind, what should we be
10 doing in the year 2008 to prepare for that? Ed,
11 did I capture that thought?

12 DR. POLAND: Just to make the point with
13 the millennium cohort study for those who aren't
14 aware, I think now they are or soon will be up to
15 is it 100,000 service members who will be followed
16 up into 2020 or beyond. Bill, I know you were
17 there. Would you like to make a comment?

18 DR. HALPERIN: Yes, I think you did a
19 very nice summary of this. I really think that
20 this is a national treasure with great potential
21 like the Nurse's Health Study to answer questions
22 for decades to come some of which may actually

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 start with earlier results than 2020 since it is
2 prospective and some things have shortened
3 latency. I think there's one issue and it may be
4 because you were being too politic and I'm going
5 to be indelicate, I don't think that the issue is
6 just a matter of career ladder, but given the wide
7 potential of this very, very large prospective
8 cohort study, this entity, this group, really
9 ought to be embedded in an arena, in an
10 institution where there is a lot of epidemiology
11 going on, where there are people with creative
12 ideas that no one person or no small group of
13 researchers can think of. So it's really are they
14 embedded in the right place? Is there a place
15 within DOD where there's a greater accumulation of
16 epidemiologists and clinical researchers and
17 others? Or even conceivably ought it be seconded
18 in a major university?

19 DR. POLAND: Bill, thank you for making
20 that point, and I don't think it's indelicate. In
21 fact, I think it's critical to the continued
22 success and to mine everything out of this that

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 this treasure offers. You have brought it up
2 previously, I think it's one of the points that
3 we'll want to dig into on this next visit.

4 DR. MILLER: I couldn't agree with you
5 more that this is a national treasure and the
6 opportunities that you're mentioning are really
7 quite extraordinary both for research advances in
8 biomedical sciences and population- based health.
9 I would echo, Bill, what you just said. I don't
10 have too much information about the size, scale,
11 and scope of this program, but I have two
12 comments. One is, questions of whether it already
13 has linkages, I'm not aware of any linkages of
14 this research institution with the NIH, for
15 example, and partnerships there that could be
16 envisioned in terms of helping to support the
17 research and offer up effectively the mechanisms
18 to allow civilian- military interactions to foster
19 a research agenda.

20 The other question or comment I have is
21 related to how research is usually funded.
22 Frequently research can be funded on a very

 ANDERSON COURT REPORTING
 706 Duke Street, Suite 100
 Alexandria, VA 22314
 Phone (703) 519-7180 Fax (703) 519-7190

1 short-term annual basis like our congressional
2 cycles or how more appropriately it should be
3 funded is longitudinally over longer time periods
4 without guarantees of out year so research can
5 take on a scale and scope that is above and beyond
6 just annual fiscal cycles much like what the NIH
7 has for out-year funding so it transcends the
8 political process. I'm not sure if the stability
9 of the research funding line for this entity is on
10 an annual basis as I suspect it is or if it's
11 longer term.

12 DR. POLAND: No, it's not annual, but
13 the duration was unclear.

14 DR. KAPLAN: It's congressionally
15 mandated.

16 DR. POLAND: The funding does come that
17 way. They fund it through 2015 and they're hoping
18 it to 2020. Is that what I recall?

19 COLONEL GIBSON: It's funded for a
20 20-year period as part of a POM so it's annual
21 funding that is fenced, if you will. That's the
22 wrong word, but basically that's what it is. It's

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 money that's set aside directly for that. In
2 addition to that, and the folks at the Naval
3 Health Research Center who oversee the Deployment
4 Health Research Center from an organizational
5 standpoint are very careful to ensure that when
6 somebody decides that they need to do more in a
7 specific area using these data or add questions,
8 et cetera, that money comes with that. One of the
9 big issues, one of the big concerns that I have
10 with this is mission creep as it relates to
11 funding. It's very easy to add just another
12 couple questions, but it opens up an entirely new
13 set of analysis that eats up people and time.

14 DR. POLAND: And they themselves
15 articulated that, actually. Dr. Shamoo, you've
16 been patiently waiting.

17 DR. SHAMOO: Just on the process. Since
18 you overemphasized that these were impressions,
19 did you have with them, since you're making a
20 recommendation on your not so confident
21 impressions, basically, did you have an exit
22 meeting with them telling them these are our

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 impressions or sent them back your impressions and
2 see how they react to it before your
3 recommendations?

4 DR. POLAND: Good question. The
5 specific answer, did we have an after-action
6 briefing with them, no, and they are draft
7 recommendations. Nonetheless, we felt pretty
8 confident because they were more or less telling
9 us these things, that these were issues, but I'm
10 saying impression because it's not like we had all
11 the data in front of us and could dig into it for
12 ourselves and we feel the need to do that.

13 DR. KAPLAN: Bill, I thought it was that
14 they did have certain projects that were in
15 collaboration with university people and so forth.
16 It's not totally within that group. Am I right?

17 DR. POLAND: That's correct.

18 DR. HALPERIN: I remember it the way you
19 did. There were certain ideas that evolved that
20 included people at other universities. It's very
21 much a creative ad hoc, if you will, as it should
22 be, but that doesn't negate the idea that being in

 ANDERSON COURT REPORTING
 706 Duke Street, Suite 100
 Alexandria, VA 22314
 Phone (703) 519-7180 Fax (703) 519-7190

1 context with a lot of people with a lot of diverse
2 ideas would squeeze even more out of it.

3 DR. ETRE: If I could just make a
4 comment. When you mentioned that you recommended
5 a triage to sort of sort out what the priorities
6 should be for the Department of Defense, it would
7 be perhaps desirable to see also what research
8 goes on at NIH and NSF so that we would not
9 reinvent the umbrella. The public generally
10 supports research but we don't need more
11 redundancies than we already have.

12 DR. POLAND: It's a superb point. They
13 do have, I've forgotten what they call it,
14 external oversight or something like that,
15 committee that had academics on it. Dan is on it
16 and he can comment about it. I don't think it
17 incorporated, and I may wrong, and Dan correct me
18 if I am, NSF, DARPA, NIH type folks, and it's an
19 excellent suggestion that we'll bear in mind.
20 Dan, do you want to comment?

21 DR. BLAZER: It's called the Scientific
22 Advisory Committee.

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 DR. POLAND: Advisory Committee.

2 DR. BLAZER: We meet once a year. We've
3 actually collaborated with them on some
4 publications, but typically the publications come
5 internally. They're not involving the Scientific
6 Advisory Committee, for some they've involved us.
7 I have somewhat of a conflict of interest so I
8 have to be careful what I say, but I think the
9 recommendations you make are on target. I think
10 this is a very enthusiastic group. I do think
11 this is a fantastic resource. More could be
12 gotten out of it I think than probably has up to
13 this point. That's actually not the fault I think
14 necessary of the investigators who were there. I
15 think it's more just the system that it has to be
16 in.

17 DR. POLAND: I absolutely agree. I
18 absolutely agree.

19 DR. BLAZER: But in terms of the
20 composition of the Scientific Advisory Committee,
21 it's sort of like us, for the most part,
22 academics, some who have had some work with the

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 military, some of whom have not. Obviously about
2 half of them are from the San Diego area. I don't
3 know if that's good or bad.

4 DR. POLAND: What I'd like to do if the
5 board is willing, and I checked with him in
6 advance, is to see we can't move Dr. Certain's
7 presentation up since we're well on time. It's
8 about 30 to 40 minutes. We have Special Forces
9 guys up here. I'm doing it for two reasons. One,
10 I'm well aware that when we get to the end of the
11 second day, people start rushing for airplanes, et
12 cetera, but I think what he has to say you're not
13 going to hear any place else. It's important. It
14 is even an issue in regard to his wartime experience,
15 and centers around Dr. Certain's service to this
16 nation and his time as a POW. So it's a break
17 from the hard science that we often do to sort of
18 the humanitarian, psychological, sociologic
19 aspects. So that he doesn't feel a conflict of
20 interest, let me just say it. He's written a book
21 which I was privileged to read and I would commend

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 the book to you. Perhaps he can give some details

2 about it, but it is at least particularly for me
3 as a kid living through two of my dad's
4 deployments to Vietnam, it was poignant to me and
5 heart rendering in many respects, Bob. So please
6 take the time that you need and then we'll go into
7 administrative session.

8 COLONEL CERTAIN: All I have to do is
9 figure out how to do this.

10 COLONEL GIBSON: This briefing would be
11 in the day two group. I would suggest that we
12 take 15 minutes to get everything set up and then
13 come back if that's okay. Make it 10.

14 SPEAKER: Okay, can you please take your
15 seats? As I mentioned, our last speaker for the
16 day is Rev. Robert Certain. He's the Interim
17 Rector at St. Peter & Paul Episcopal Church in
18 Marietta, Georgia. Rev. Certain left active duty
19 in 1977, and retired as a Chaplain in the Air
20 Force Reserves in 1999. I won't read all his
21 numerous awards and decorations, but I do want you
22 to hear what he has to say, particularly how it

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 might apply to the health implications for

2 prisoners of war. And I think -- do we have
3 slides? -- under Tab 13 you'll find his slide set.

4 REV. CERTAIN: Interesting tab.

5 SPEAKER: That was not planned.

6 REV. CERTAIN: No, I'm sure it wasn't.
7 And one change -- my Bishop has psychological
8 problems, too, and I'm no longer the Interim
9 Rector. He's asked me to stay on for an
10 indefinite period of time. He had a weak moment.

11 "The Unchained Eagle" is the title of
12 the book. This is it? And I just brought that as
13 an example, but if you're interested after you've
14 heard me talk, if you're still interested in
15 reading the book, then you can write to me at the
16 address in the materials you have, and I sell them
17 for a 30 percent discount below Amazon. So -- and
18 I sign the ones you buy from me. I don't sign the
19 ones you buy from them.

20 All right. POW stuff. I was a B-52
21 navigator in the -- starting in 1969, and was
22 taught in survival school that when you're

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 captured, you're required to give this

2 information: Name, rank, service number, and date
3 of birth. Service number is incorrect by the way;
4 I do have a little bit of sense. And -- but I was
5 also told that if you were ever to be captured,
6 you should have a cover story. Just keep it
7 simple stupid and a few details that you're not
8 likely to forget under torture. Being a B-52 crew
9 member, I was invincible. Being 23, I was
10 invulnerable, and so I didn't have a cover story.
11 That was one of my problems as it got along.

12 The B-52 Stratofortress is what we flew.
13 Arclight was the codename for most B-52 missions
14 in Southeast Asia and generally involved D-model
15 B-52s. This is a G-model in the picture. I flew
16 one tour in -- of Arclight -- out of Thailand in
17 the fall of 1971, had 50 combat missions in four
18 and a half months, then rotated home, got married,
19 and you know, I was sent back for Bullet Shot.
20 Bullet Shot was the movement of G-model B-52s to
21 Guam to enhance the war effort starting in the
22 spring of 1972. When we started going over,

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 eventually about 50 airplanes went to Guam. There

2 were about 100 D-models, about 50 G-models in the
3 theater. For those of you not familiar with the
4 aircraft, it's an eight-engine jet with -- we
5 could carry up to one hundred and eight 500-pound
6 bombs in the D-model, fewer than that in the Gs.
7 We flew -- it's twenty-seven 750-pound bombs in
8 the G-model. We had a crew of six. In the
9 D-model, five crew forward -- five crew members
10 forward, one aft. The tail gunner was in the
11 tail. In the G- and H-models, the tail gunner was
12 actually up front with the rest of the crew, and
13 basically that way the crew -- the crew
14 compartment is from here forward. Everything else
15 is fuel and bomb.

16 This was -- on the 18th of December, the
17 crew was -- my crew was part of the first night of
18 what was called Linebacker II when President Nixon
19 ordered B-52s to bomb Hanoi to force a treaty to
20 be signed, preferably before Congress came back
21 into session in January. And the reason for that
22 was that while Nixon won an overwhelming victory

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 in the fall of '72, he lost the Congress. And he

2 was convinced that funding would be cut off and
3 the prisoners would be left behind, and he didn't
4 want that to happen. Charcoal 1, this is Charcoal
5 cell, this is where we were flying. As Charcoal 1
6 we were the number one airplane -- each color here
7 is three airplanes, and we would be the number one
8 airplane in a wave of nine aircraft, and we were
9 in the third wave of aircraft -- or fourth -- to
10 come out of Hanoi ahead of Guam into Hanoi. Now
11 if you know your geography, you know Guam is east
12 and we're coming from the west. That's because we
13 crossed into South Vietnam, up through Laos, and
14 up as you can see to the China border, which was
15 right here at about 45 miles from the China border
16 before we turned into the target, which was here
17 on the northeast side of Hanoi here. Needless to
18 say, it was not a real good idea what we were
19 doing. It was really kind of dumb, but necessary
20 because there are all these circles here that are
21 lethal SAM zones, so anything inside of there
22 you're within lethal distance of an SA-2 missile

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 site. That's an SA-2 missile, about 30 feet long,

2 looks like a flying telephone pole. And contrary
3 to the typical civilian idea that missiles do not
4 hit you, missiles blow up and you fly into the
5 trash. And this -- it's like a shotgun shell --
6 it sends out broken pieces of shrapnel in all
7 kinds of directions, and it punctures the
8 airplane. When you have jet engines and you suck
9 a piece of shrapnel into an engine, that engine's
10 gone. We had eight jet engines on the bomber
11 starting the bomb run; we probably had none at the
12 bomb release point because we were hit at 1313
13 GMT, just 10 seconds short of the bomb release
14 point.

15 The first night -- over the course of
16 the so- called Christmas war, the eleven nights of
17 bombing of Hanoi, ten airplanes were downed over
18 the city, five more were damaged by surface-to-air
19 missiles and did not make successful landings;
20 however, they did get into Thailand, and the crews
21 were able to eject over friendly territory and
22 were rescued. One of the aircraft a little later

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 in the week crashed into a lake in the center of

2 Hanoi, and it's still there as far as I know.
3 This is a fuselage of the airplane and you can --
4 in the same lake -- and you can see landing gear
5 poking up. My aircraft landed in this rice field
6 north of Hanoi, and that's the monument they
7 built. They built a monument to my aircraft
8 because we were the first B-52 they ever shot
9 down, and I was the first one of my crew to be
10 captured, not something I generally add to my
11 résumé line. And so this is out on the north side
12 of town, out in this rice area. And you'll notice
13 the one thing that is lacking in this picture is
14 trees. You can see some back here along in there.
15 And every time there's a little bit of tree out
16 there, there are also houses, which made a big
17 difference when I was coming down in the parachute
18 because there was no place to hide. So
19 consequently I was captured rather quickly. I hit
20 -- I was shot down at 1313 Greenwich -- ejected
21 within 10 seconds of the first missile strike.
22 The pilot was mortally wounded, the gunner was

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 killed, the airplane was on fire. We had a full

2 load of bombs and about 120,000 pounds of jet
3 fuel, and the fire just struck me as a real bad
4 combination. One crew member ejected -- the
5 Defense Officer -- that was a real bad sign. And
6 the pilot who was still alive ordered the crew
7 out, and he and I probably ejected mostly
8 simultaneously. He went up, I went down. The
9 bombardier, in accordance with his procedures,
10 waited until he was sure nobody was coming
11 downstairs to jump through the hole I had made,
12 and then he ejected and managed to evade for about
13 12 hours before he was captured. When I landed
14 about 15 minutes after I left the aircraft -- we
15 left at 35,000 feet, free-fell for 20,000 -- and
16 when I landed I was surrounded basically by mostly
17 civilians and four militiamen with AK-47s. I was
18 grateful for the militia because they protected me
19 from the civilians because civilians didn't really
20 like me dropping in on them like that. And then
21 -- so I was taken in kind of quickly to the Hanoi
22 Hilton. This was my EW, my Electronics Warfare

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 Officer. He was taken in with me. I was shown

2 the pilot -- my pilot's body on the ground so I
3 knew he had died. Early the next morning another
4 B-52 went down. And they were able to capture
5 four men off of that crew so that by noon on the
6 19th of December, they had six crew members from a
7 B-52, so that basically a full crew.

8 They took us in front of the
9 International Press Corps. At that point we'd
10 been interrogated -- I'd been interrogated all
11 night, been roped all night, had been beaten just
12 a little bit because they didn't like my answers.
13 I had said I had to make that cover story up on
14 the way to the ground, and so my cover story was I
15 was just a celestial navigator and that's all I
16 knew was navigating over water. And throughout
17 the interrogation, they kept telling me that if I
18 didn't tell them what they wanted to know, they'd
19 take me where the B-52s were bombing. And I was
20 pretty sure they weren't going to do that because
21 they didn't seem to be real excited going anywhere
22 near B-52s. It was a lot safer in the prison than

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 it was anywhere in town because we knew where they

2 were. The picture -- my picture there makes it
3 look like I'm not a real happy camper, but I'd
4 been up all night. I'd been up for about 36
5 hours, and -- but I was jumping for joy inside of
6 me because my picture was being taken by
7 Europeans. So the International Press Corps. was
8 there and I knew that my picture would be
9 released, my name would be released, and my family
10 would know that I was a prisoner and not in that
11 nebulous state of missing in action or that
12 terrible state of having died in action. So I was
13 pretty thrilled about all of that. And I could
14 have been wondering why Joan Baez was sitting in
15 front of me, but I wasn't. She was there, but I
16 didn't notice.

17 We were kept in the Hanoi Hilton. This
18 is an overhead sketch of the prison. Back here is
19 where the bad guys were, that is, the older
20 prisoners of war who were hard as nails and very
21 rebellious by this point in their career. And us
22 new guys were kept out, just inside the main gate

 ANDERSON COURT REPORTING
 706 Duke Street, Suite 100
 Alexandria, VA 22314
 Phone (703) 519-7180 Fax (703) 519-7190

1 here, in what had been interrogation rooms along

2 in these two wings of the prison. That is until
3 our door fell off one day,
4 overpressure/underpressure had done that. An
5 F-111 dropped a 250 pound bomb on a triple-A gun
6 about a block away. And so the
7 overpressure/underpressure of the bomb drop
8 knocked one of the doors off of our cell,
9 rendering it basically useless for keeping us
10 inside. Although I was a 5 foot 9 inch albino
11 redhead and my cellmate was a 6 foot 2 inch
12 African American, and neither one of us would have
13 passed for locals, we weren't going to go out
14 there on the streets anyway.

15 But from there we moved into this place
16 here, this little wing. It's what we called the
17 Heartbreak Hotel. It was kind of a torture
18 chamber, a very grim, dark, nasty, dank place
19 filled with rats which loved to crawl on us at
20 night. And we were there for a couple of weeks,
21 and moved back out to another cell out here until
22 mid-January when we were moved to another prison

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 as they reorganized the prisoners in order of

2 shoot-down date. There were four prisons still
3 open after Son Te -- after the raid on Son Te --
4 which didn't rescue anybody but really rattled the
5 North Vietnamese. They closed most of the
6 outlying camps save one up on the China border and
7 three in town. You've heard of the Hanoi Hilton.
8 You've probably heard of the Plantation Gardens.
9 It was called that because with the Big House, Big
10 House here, and this courtyard and kind of shotgun
11 places, it looked like a Southern plantation in a
12 lot of ways. Built by the French and so the Manor
13 House looked a lot like a French Manor House from
14 Southern Louisiana. So it was -- but this was
15 kind of the showoff place. This is where we were
16 taken to have our pictures taken, and this is
17 where the peace committees came
18 The other prison in town was called -- we
19 called it The Zoo. It had been either a French
20 Officer's quarters at one time and it was also

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

258

1 used as a movie studio at one time. And these are
2 basically the names we gave to the various cell
3 blocks. The Pool, however, was a real swimming

4 pool. Not one you'd want to get in because the
5 water was nasty, but we would -- and there were
6 walls around all of these various structures to
7 restrict movement and communications. And this is
8 where I spent the last about 80 days. I was only
9 there for 100 and well, about 60 days, 70 days I
10 guess. We were there from mid-January -- the
11 treaty was signed the end of January -- and we
12 were released out of here on the 29th of March.

13 This is what's left of The Zoo. It
14 doesn't look any better now than it did then.
15 This picture's two or three years old and shows
16 kind of the construction and what it looked like.
17 This was what it looked like in my cell the day
18 before release. That's me there. And we were
19 standing at parade rest, quite frankly to irritate
20 the North Vietnamese. When we realized that the
21 International Press Corps. was coming in, we
22 decided to fall into military formation and then

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

259

1 to behave like military officers because we knew
2 the Vietnamese hated that, and it also gave us a
3 little bit of pride to do so.

4 The treatment for me was pretty minor.
5 According to Will and Sybil Stockdale's book, "In
6 Love and War," the torture ended in two phases,
7 started when the infamous Hanoi March occurred,
8 which started an international letter-writing
9 campaign demanding better treatment of prisoners
10 of war. And then according to Stockdale's book,
11 the day after Ho Chi Minh died in October '69, the
12 torture ended the next day. So I didn't know
13 that, and so I was prepared -- trying to prepare
14 myself for anything. I was beaten a few times. I
15 had some physical abuse the first little while. I
16 had multiple interrogations heavily for the first
17 several days, and then after that periodically
18 because, like most military organizations, the
19 interrogators were required to fill the training
20 squares. And it was like they were going through
21 the motions of interrogating us, asking us really
22 strange questions like who the commander was at

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

260

1 Guam. And I was just a celestial navigator; I
2 didn't know who the commander was. Always threats
3 of greater harm, they wouldn't let us go home, we

4 would die over there, to be taken where the B-52s
5 were bombing, et cetera. After the bombing ended
6 in January, we were taken out on a couple of
7 occasions for propaganda films, and we tried to
8 indicate our distaste for that through hand
9 gestures.

10 Poor hygiene was the name of the game.
11 The place was nasty, filthy. We got baths about
12 once a week or ten days. We couldn't wash our
13 clothes very often, and the toileting facilities
14 were -- well, let's say they weren't much. We had
15 five-gallon buckets in the cells, generally
16 unsanitary living conditions, and terribly
17 unsanitary food. The diet was -- this later
18 becomes, about ten years ago, a fad diet in the
19 United States. A breakfast was half a loaf of
20 French bread and some powdered, reconstituted,
21 powdered milk that came from Poland, very, very
22 sweet. Lunch and dinner was half a loaf of French

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

261

1 bread, a bowl of cabbage soup, and weak hot tea,
2 day in and day out. The only variance was on
3 Sundays when we only got one meal.

4 I was repatriated in the last group to
5 leave Hanoi on the 29th of March, 1973. I spent
6 about three days in the Philippines, came to a
7 medical facility at Scott Air Force Base in
8 Illinois for a rigorous physical, and then was --
9 the crew was moved back to Blytheville Air Force
10 Base in Arkansas, our starting point, to be
11 welcomed home by our friends. Our families had
12 met us up at Scott. At that point I was told to
13 go back to Scott because they thought I had
14 malignant lymphoma. I didn't have a clue what
15 that meant except it sounded nasty.

16 Since the war in Vietnam, medical
17 following of the Vietnam POWs -- and this is very
18 different from World War II or Korea -- has been
19 conducted primarily as a result of the efforts of
20 this one Navy doctor, Robert E. Mitchell, for whom
21 the Center is named now down at Pensacola Naval
22 Air Station in Florida. It became first just a

 ANDERSON COURT REPORTING
 706 Duke Street, Suite 100
 Alexandria, VA 22314
 Phone (703) 519-7180 Fax (703) 519-7190

1 medical following of the Navy and Marine Corps.
2 former POWs, to make sure they were doing okay
3 over time. That started as soon as repatriation

4 occurred and then developed from there into a
5 longitudinal study of the effects of incarceration
6 and depravity -- depravation rather, depravity is
7 something, I mean, that's every Navy aviator. The
8 Matched Comparison Group was called in in 1976, so
9 just three years into the process. The Navy --
10 the Air -- the Army stopped following their former
11 POWs fairly quickly after the first year. There
12 weren't that many of them. There were very few
13 men kept alive in South Vietnam, and very few --
14 The Army transported north into Hanoi so most of
15 us were aviators from one of the three services
16 that flew jets and bombers with the Army being the
17 smallest of the groups. The Air Force followed us
18 for about three or four years with annual
19 physicals, and then declared us all fit and
20 healthy and sent us home. And so -- they did not
21 do this -- Dr. Mitchell had other ideas. When the
22 Gulf War ended, there were fewer than a dozen men

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

263

1 and women who were held as prisoners, and they
2 were included in the study at that point in '91.
3 And then '94 the USAF POWs from Vietnam were

4 added, and two years later the Army. We got -- we
5 are funded separately now from the Navy budget,
6 and we are invited to come to Pensacola once a
7 year for an annual physical that generally lasts a
8 day and a half to two days, depending upon the
9 kinds of things that they're poking and prodding
10 for at this time. And then they refer us back to
11 our civilian doctors or VA physicians, wherever we
12 get our primary care.

13 My concern here on this Board -- and
14 then I'll get to the next 45 minutes or less -- is
15 post-traumatic stress disorder, and I'll try to
16 defang all this stuff from the psychiatric
17 diagnosis. And being a storyteller and not a
18 scientist, I refer to it as the "ghost of
19 Christmas past" that likes to come out and haunt
20 us from time to time. Ten years' home is when I
21 first learned about -- learned intellectually
22 about -- anniversary anxiety. I had no

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

264

1 intellectual hanger for that before. I'd been
2 trained in seminary. I went to seminary as soon
3 as I came home from Vietnam, and I was trained to

4 do theological reflection, to use that as a lens
5 to ask what's going on in your life, in your
6 relationship with God, and what's God doing in
7 your life. But I was never encouraged or taught
8 or any other way forced to put that lens on my own
9 life, and so I hadn't done that yet. But
10 anniversary anxiety was something I learned about
11 in counseling courses I was taking, and realized
12 that Christmas to Easter was always a difficult --
13 the worst -- the most difficult time in my life as
14 a young priest. And so I first thought that had
15 to do with my life as a priest, then I began to
16 think about it and realized it was also the
17 bookends for my incarceration. I was shot down a
18 week before Christmas and was released about a
19 week before Holy Week. The other thing that I
20 came to learn over time about the ghost of
21 Christmas past was embedded memory, and that was
22 from -- began to understand that from a study of

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

265

1 neuro-linguistics in the 1980s, and to look at the
2 themes of life and how they play themselves out in
3 people's life over time. And that would be again

4 to form another way of going back and finding out
5 what the long arm of Vietnam was in my own life.
6 Finally, the effort to exorcise the ghost was
7 completed, at least I hope it was, in 2001 through
8 a specific therapy called EMDR, Eye Movement
9 Desensitization and Redirection, which is kind of
10 a spooky therapy and is probably looked at askance
11 by a number of psychological and psychiatric
12 therapists.

13 Anniversary anxiety. This was the
14 Christian -- these were the Christian seasons in
15 which I found myself most filled with tension,
16 starting with Advent, the season before Christmas
17 and leading all the way up to Christmas Day.
18 During the -- it was the busiest time of the
19 liturgical year for an Episcopalian, we like to do
20 good, additional instructions, a lot more
21 liturgies, it's -- everything has to go well
22 because that contains the two Holy days where

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

266

1 everybody comes to Church at the same time,
2 Christmas Eve and Easter Day, so it was a very
3 busy and stressful time for a priest, but as I

4 said also the bookends of incarceration. So I
5 started asking myself the question which one was
6 causing more stress? The final flight that led to
7 my incarceration or was it just daily life as a
8 clergyman? And that was sort of how it went. Now
9 here's what I learned in EMDR therapy and studying
10 the themes of post-traumatic stress disorder. I
11 learned for me anyway that post-traumatic stress
12 did not mean I was reliving the past. My
13 flashbacks didn't have to do with specific events
14 that happened on the 18th of December, 1972, or
15 any of the hundred days that followed that. It
16 had rather to do with the themes of that final
17 mission, and this is what they were. First of
18 all, grave disappointment. This was the day my
19 crew was supposed to go home. We were done. We
20 flew our last mission on the 14th of December, and
21 we were to leave. That was a Thursday and we were
22 to leave Monday for the States, and on the 15th of

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

267

1 December, our orders were cancelled and we were
2 told to stand by. And so we were very
3 disappointed that we were going to have to fly one

4 more mission. That was the first one. Then there
5 was another theme that occurs in the story or
6 unexpected or uncontrollable events. For
7 instance, as we were taxiing out, we were stopped
8 on the taxiway when there was an earth tremor on
9 Guam. Now you just don't control those all that
10 well, and so there was nothing -- but you have to
11 live through it, you have to adapt to it and go
12 on. Two airplanes ahead of us aborted because of
13 bad airplanes, and the drill was if your airplane
14 was bad, you went to another airplane and you went
15 to the tail of the line and took off at the tail
16 end. And so everybody else moved up one, so as we
17 were taxiing out, somebody's airplane was bad and
18 we moved up one. As we took the active runway and
19 began our taxi, our takeoff, we were notified that
20 somebody else had aborted and we moved up another
21 one. So we went from Charcoal 3 to Charcoal 1,
22 and then as we took off, as we got to the altitude

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

268

1 at which the pilots pressurized the crew cabin, it
2 wouldn't work. It wouldn't pressurize. That was
3 an abortable deal. We could have declared the

4 airplane broken, but the bombardier got out the
5 repair manual and fixed the problem so we could
6 continue flying. So then we were overcoming these
7 obstacles. We rendezvoused with a tanker, correct
8 beacon code, correct conversation, all that stuff,
9 wrong airplane. We had a visual on him, wrong
10 airplane, talking to a different guy. And so
11 either the airplane we rendezvoused with was
12 putting out the wrong beacon code, or I had made a
13 terrible mistake as the navigator since that was
14 my job to rendezvous with the right one. The
15 other guy with the right one was 50 miles away,
16 and we had to catch up. When we got to the
17 compression point where these nine airplanes were
18 to go from a five-mile separation to a one-mile
19 separation, the two cells behind were scheduled to
20 be at that point at the same at the same altitude.
21 That's not a good thing when you've got six B-52s
22 trying to occupy the same space. Unfortunately,

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

269

1 they discovered it as they approached the space
2 and were able to wiggle around and slow down and
3 speed up and get into proper order. The next

4 thing we could nothing about -- of course, we're
5 all the SAMS, second most heavily SAM-defended
6 city in the world, next only to Moscow in 1972 --
7 and so we knew we were going to face that, and we
8 were hoping that our jamming equipment would work
9 and that the fighter escorts that were laying --
10 had laid down CHAFF and the other aircraft, the
11 ECM aircraft, that were doing other jamming would
12 work. And then we also knew that when we turned
13 down on the bomb run, we'd enter a jet stream with
14 a tail wind of about 90 knots -- that was the good
15 news. The bad news was that after bombs away, we
16 were to turn right back into that jet stream and
17 lose 180 nautical miles of ground speed in about
18 35 seconds. And so it was a very, very dangerous
19 space and we had all of that to go on and the
20 planning errors. And quite frankly, I hate to
21 tell you, but that mission was planned in the
22 Pentagon, not in the field. It violated SAC

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

270

1 doctrine, it violated the experience of the Navy,
2 the Marine Corps., and the Air Force, flying
3 missions over the Red River Valley, and so it was

4 not a well-planned mission. They would discover
5 that when we got to the target. And of course the
6 very grave danger that was there, and lots of
7 obstacles to overcome, including fear, including
8 all the things I've just been through. There were
9 vital goals. These goals were the -- for the
10 war-making ability of North Vietnam. There were
11 like 18 targets. We bombed -- we dropped -- 900
12 airplanes went against those 18 targets, and they
13 were all military targets. Ours was a railroad
14 yard to disrupt the movement of materiel around
15 Vietnam, and so it was important that we take them
16 out. It was more important we drop the bombs
17 because after the first five or six B-52s dropped
18 a load of bombs on a railroad yard, there's
19 nothing left to destroy. But the noise of those
20 airplanes -- of those bombs coming down and the
21 explosions is enough to rattle the nerves of the
22 guys who sign treaties and to get them back to the

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

271

1 table.

2 Then we were at certain success. As we
3 approached the target, we were 10 seconds, we were

4 15 seconds out, we were perfect. We were exactly
5 to the second on time. That was my job. I was
6 good. And the bombardier had the target clearly
7 identified, clearly wired, and those bombs were
8 going to leave our airplane on time and hit that
9 target, and we were going to go home. The only
10 problem was as I've told you at 10 seconds to go
11 in the bomb run, we were hit by the first of two
12 SAMs, and within 10 seconds we had ejected from
13 the airplane. The good news was that I did get
14 out of the airplane. The bad news was as I said I
15 ejected at the bomb-release site, and there were
16 eight airplanes behind us, going to be dropping
17 bombs every 15 seconds. And the entire time I was
18 free- falling, they were dropping bombs that were
19 falling on the same line of trajectory I was
20 falling on. I realized that when I wrote the
21 book. Then I got really scared, 30 years later.
22 Now those are the things -- now here --

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

272

1 this is an event, capital funds campaigns that
2 clergy tend to get into, was the thing where on
3 two occasions as I completed capital funds drives,

4 I also had to check in with my psychiatrist to get
5 -- to go into better living through chemistry
6 because I'd hit the wall with clinical depression.
7 And I didn't understand how it was connected, and
8 it happened -- the last time that happened was at
9 Easter of 2000, and here are the themes. I don't
10 like doing capital funds drives. I hate looking
11 you right in the eye and saying the Lord has shown
12 me that he wants you to give us \$100,000. I can
13 do that pretty well, but I don't like doing it
14 necessarily. And so I don't really like doing it
15 because of all the unexpected, uncontrolled events
16 that occur in people's lives because we're always
17 working with human beings. Now you people are not
18 controllable. There're always planning errors.
19 We plan on things and we goof them up. In that
20 last capital campaign, there were two very
21 important events, and they were scheduled one day
22 after the other and I had to be at both of them.

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 And when the invitations went out that I had
2 proofread, myself, six or eight times, the
3 invitations had them scheduled at the same time on

4 the same day in two different places. And so --
5 and then there was the danger of failure. If you
6 don't succeed, then you have failed. If you don't
7 meet your goals, then you are perceived as a
8 failure. And it's always possible that people
9 will say no and not give. All kinds of obstacles
10 to overcome with people's schedules, with my
11 schedule, with the buying into of the goals, and
12 all the rest of it, but the goals are always vital
13 to the life of the Churches that I've served and
14 important to accomplish. And just as we're
15 getting near success, my anxiety would be at its
16 highest, and I'd start putting out résumés and
17 looking for a place to go. And so I never
18 connected these events. I never connected the
19 anxieties I would feel during capital campaigns,
20 and oh by the way, we always do those between
21 January and April. It's just when they're done in
22 my history. And so all of that was there, and I

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

274

1 never connected to one 8 hour and 40 minute period
2 of time on the 18th of December, 1972, in that
3 last meeting. So the first thing I did in 2000

4 was start writing the story down, and it was under
5 duress. I was writing it for a psychologist. I
6 was not writing it for myself. And then she would
7 force me to reflect upon the details of the story,
8 and my family, my wife and I would discuss it, and
9 some close friends would discuss it with me in
10 addition to the psychologist at the Vet Center in
11 San Bernardino. And then I got better and the
12 Zoloft was helping and all that stuff. I went off
13 to my physical at Pensacola that summer, and the
14 doctor there said you know Bob, I really think
15 you're suffering from PTSD, and if you're -- and I
16 -- and here's a therapy that you might find
17 helpful because it's really helping some of our
18 guys that are coming through here. And I thought,
19 well, that's very interesting doctor, I'll look
20 into it, and I filed that for about a year. And
21 what happened was on September 11, 2001. All the
22 anxieties came -- rose up in the wrong month of

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

275

1 the year. And that's when I looked into EMDR as a
2 possibility for me, and the EMDR therapist over
3 the next two or three months helped me explore the

4 themes and connect the dots and to figure out what
5 was going on and amazingly to come up with
6 alternate choices for decision making and
7 thinking. And so finally, when all that was done,
8 life was better and I've had a pretty good career
9 since then. This was a high point in my life. In
10 January of last year, when I officiated at the
11 funeral of President Ford, the -- and what I do,
12 have been doing in the last couple of years is
13 trying to help people take this sort of parable,
14 if you will, in my individual story, and try to
15 understand its themes as they relate to their
16 lives, particularly our combat veterans as they
17 come home to say, you know, there may be something
18 that you experienced over there that if you will
19 take a look at it, you might find a better way of
20 living today. And I use every image I can think
21 of, and try to avoid the psychiatric diagnosis
22 titles because I'm not a psychiatrist and I'm not

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

276

1 a physician. But I am a fellow pilgrim who has
2 experienced something of the long- term affairs
3 effects of having been in combat. And so I think

4 that every one of us who come out of combat, come
5 out as combat changed. We're different people
6 when we come home than we were when we went, and
7 what we can do -- if we allow it, all the bad
8 stuff that happens to us, all the bad emotions,
9 all the troubling times, all the moral dilemmas,
10 everything else, can hamstring us in our present
11 and our future.

12 And what we do on the Defense Health
13 Board in psychological health is to try to bring
14 out something different. And what I try to do is
15 to use theological imagery with folks. One of the
16 stories I like to tell, it's like panning for
17 gold. You've got to wash away a lot of mud to
18 find the value in some of the combat experience,
19 and to use the Christian Church, the private
20 confession is a time to rid of -- to find
21 forgiveness and for the guilt that we come home
22 feeling, everything from survivor guilt to the

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

277

1 guilt we have from enjoying killing and destroying
2 and everything in between. And there are a lot of
3 tools that we can use. You have a lot of them in

4 the Defense Health Board. The Churches and the
5 faith communities of our country have a lot to
6 offer as people address the wounds of the soul,
7 and those of us who are veterans and have been
8 there and come back and have figured it out, at
9 least partially figured it out, can help other
10 pilgrims along the way.

11 So I thank you for your time. I don't
12 know how much time I took, but I took all the time
13 I was going to. And I appreciate being asked to
14 do this by Dr. Poland, and I really appreciate him
15 taking the first briefing after lunch when we were
16 all sleepy! Thank you. Any rebuttal, questions,
17 comments?

18 SPEAKER: No rebuttal. Words aren't
19 really adequate, Bob. First how sorry I am that
20 you or any service member would have to go through
21 what you did. At the same time, I have to say
22 flooded with pride in you as an individual and as

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

278

1 a service member and as an American. So thank you
2 for your service and for the journey that you've
3 traveled, which we've gotten a taste of difficult

4 it is, so thank you for that.

5 REV. CERTAIN: Thank you. I'm convinced
6 that other people don't have to be as slow and
7 stupid as I have been, and that we can actually do
8 this a lot faster than 30 years for the current
9 generation if we pay attention to them, rather
10 than having them dig it out on their own.

11 SPEAKER: Boards and commissions and
12 task forces can be slow and stupid some times,
13 too, so I'm depending on you and your experience
14 to be the accelerant in our mission to try to
15 improve the lives of service members. Any
16 comments or questions that anybody would like to
17 make? Please.

18 QUESTIONER: Thank you for sharing that
19 very personal story, and the one question and
20 comment that I'd like to make is that -- do you
21 think that because of the stigma, and then also
22 the consequences that are associated with a

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

279

1 service person revealing something that has to do
2 with mental health and mental illness, that that
3 prevents people from being open to accessing

4 treatment more readily? And even the kind of
5 treatment that's being available to them when they
6 come back with some of those issues?

7 REV. CERTAIN: Well, anecdotally we hear
8 that in recent months, to the point that
9 apparently the Secretary of Defense and the Chief
10 of Staff have encouraged their senior officers to
11 come in, to seek some psychological and
12 psychiatric counseling. From my own part, I
13 wasn't crazy. And besides, I was only there 100
14 days. I was not a real Vietnam veteran because I
15 was never in Vietnam except as a prisoner. I was
16 there in prison at a time when there was no
17 torture, and it was -- compared to what the
18 long-term prisoners went through, it was kind of
19 like a country club. And our lives were never
20 really threatened. So it took me until 1982 to
21 recognize that I was really a Vietnam veteran, and
22 it was about the same year that the POWs -- my

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

280

1 wife and I hadn't been to a POW reunion in over 20
2 years -- and that they sought me out and said hey,
3 you B-52 guys need to start coming with us.

4 You're one of us. And so I was in all kinds of
5 denial. And I think that's one of the defense
6 mechanisms that we have, and so yes, I think that
7 psychiatric designations -- as helpful as I've
8 found them looking back, and as helpful as that
9 psychiatrist and psychologist looking back --
10 looking forward to going to anybody in the mental
11 health field carried a stigma. The insurance
12 companies clearly think it's a problem you ought
13 to be able to solve on your own because the
14 reimbursement's only 50 percent, whereas for
15 "real" medical problems it's 80, or was in the
16 day. And so there's all kinds of social and
17 economic and structural and stigma attached to the
18 designation. That's unfortunate. I don't know
19 anyway around it. That's why I like to tell
20 stories and see if people connect to the story
21 first, and then tell them how I found some relief.
22 And for me it was three pronged: It was

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

281

1 theological reflection. It was writing therapy,
2 which I didn't realize that's what I was doing
3 until after I did it. And it was psychological

4 therapy. And it was actually four pronged: And
5 psychotropic medication. So now I can tell the
6 story, get somebody gripped into their own story,
7 and then say here's a combination of things you
8 might want to try because these -- this is what
9 helped me. And then the stigma gets reduced, and
10 they're willing then to do whatever's necessary to
11 get better.

12 QUESTIONER: Thank you for sharing your
13 story. It's Bill Blazek here. And thank you for
14 your service. A question I have is what sort of
15 medical care did you receive when you were
16 imprisoned, if any, and do you have any comment in
17 the role of physicians or any other healthcare
18 providers while you were in prison?

19 REV. CERTAIN: Medical care for us in
20 prison was not real good. The -- we were
21 basically on our own. The first time that we had
22 a medic come by the cell was -- it was up into

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

282

1 January. The bombing had stopped and we were in a
2 cell with about seven guys. Alex and I who had
3 been together the whole time and would stay

4 together the whole time were in a cell with five
5 other guys, all of whom had some kind of festering
6 wound, usually caused by burns in the airplane
7 before they ejected or puncture wounds. Upper
8 ejection seats -- we had a pin holder on our left
9 bicep in our flight suits, and the pins would tend
10 to get jammed or caught on the hatches as we went
11 out. So we had a couple of puncture wounds. All
12 of them were infected. We'd been locked in this
13 cell for a while, and hadn't emptied the honey
14 buckets in about five days, and hadn't bathed in
15 about two weeks, and hadn't washed our clothes in
16 about three. When the kitchen guy came by with
17 lunch one day, he took -- he gasped, put the soup
18 bucket down and told us to open the back window
19 because we needed fresh air, and he refused to
20 come in to serve us our meal. We had to come out
21 and get it. I guess we smelled bad. But as a
22 result of that, the camp commander came by and

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

283

1 gave us a lecture on personal hygiene, and then we
2 gave him a lecture on how we didn't have
3 opportunity for that and we had infections that

4 couldn't be treated, and that was the first time
5 we saw a medic who came in and cleaned out the
6 infections. Then that was about it. You really
7 had to have some significant medical issue in
8 order to get anybody to come talk to you. That's
9 why some people came home with badly set broke
10 bones and all kinds of scar tissue and stuff
11 growing up around where bones had been set badly,
12 and ligaments had been torn and never properly
13 treated. And some of the old guys were like that.
14 They did, you know, when we came home.
15 U.S. medical care, by the way, took
16 over. We were treated very, very well, and some
17 guys had their limbs re-broken and set properly,
18 surgery to correct dropped ankles and other
19 things. So we were really -- for 1972-1973, got
20 very, very good medical care. And oh, by the way,

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

284

1 they discovered I didn't have malignant lymphoma
2 after all, but that was some ninety days before I
3 got that word. But they looked at everything,
4 trying to find out what the symptoms were all
5 about.

6 QUESTIONER: If I might? George
7 Anderson. I was one of the flight surgeons down
8 at Brooks in the middle '70s who worked on
9 returning to flying status for many of the POW
10 returnees. This last string of comments from you
11 reminded me of that experience because primarily
12 we were working on orthopedic problems and trying
13 to see if the aviators could pursue their
14 occupation anymore. And of course the problem
15 with that is they went through a full
16 psychological and psychiatric evaluation, but they
17 wanted to get back to flying, and so they weren't
18 going to be telling us a whole lot about what
19 their mental health status was, and these guys
20 were really motivated. And I just want to express
21 to you what that was like. I would go -- I
22 remember one fellow that had extremities broken on

 ANDERSON COURT REPORTING
 706 Duke Street, Suite 100
 Alexandria, VA 22314
 Phone (703) 519-7180 Fax (703) 519-7190

285

1 ejection -- he was a high-speed ejectee -- and he
2 wanted to get back to flying jets, and so we took
3 him up to Randolph and put him in a T-38 and made
4 sure he could hold the brakes at mil power so he
5 could operate. That was the test, so the flight

6 surgeon's watching this. There is no way that guy
7 was going to say anything about his mental health
8 status because he was going to fly again. You
9 might reflect on that.

10 REV. CERTAIN: Well, exactly. We were
11 fine. We were out. This was our mental state.
12 Yeah, you know, we had nightmares, but doesn't
13 everybody? There was nothing that we chose to
14 take to the doctors. You didn't have any better
15 chance than we did, I'll grant you that. Like I
16 said, we were given more medical care in 1973 than
17 our compatriots who were not shot down, but
18 denial's a big part of it. We don't get affected
19 by this stuff, just ask our wives. They will
20 contradict us. And so, we wanted to get back to
21 work. But I'll have to tell you, what I did; I
22 didn't go back to flying. I was offered any --

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

286

1 the DOD said you could have any job you want as
2 long as you're medically qualified, and I said
3 well, I'm going to seminary. They said well,
4 that's not what we meant. But they sent me
5 anyway, and I should have known something was

6 wrong because there were times in seminary I would
7 just soon been back in Hanoi because I was in a
8 foreign land in seminary. Seminaries in 1973 were
9 populated by people who didn't like the war in
10 Vietnam or anybody who ever fought there. And the
11 country was glad to be gone -- it shuttered the
12 thing and was struggling through the troubles of
13 President Nixon and the potential of impeachment,
14 and then the change to Gerald Ford as President
15 and all that went with it, the pardon and
16 everything else. So we Vietnam veterans were the
17 lightning rod to a lot of social angst that had
18 developed over -- throughout the 1960s and had --
19 then was coming to a point in 1973 with President
20 Nixon. So it was not a pleasant place to be, and
21 it wasn't me that was having the problem. It was
22 society. We misinterpreted all the signs -- when

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

287

1 you look at -- you know, hindsight is a wonderful
2 thing. You can look back and you can see signs
3 that we could have made interventions in each
4 other's lives a lot sooner than we did. And
5 what's good now from my perspective is we are --

6 we seem to be as a country paying closer attention
7 to our Viet -- to our veterans of the current
8 conflicts than we did in Vietnam and looking at
9 them as people who have done the country's
10 bidding. And now what can the country do to
11 reincorporate them fully into normative society --
12 whatever that is -- and to be productive as they
13 return home and take their uniforms off whether
14 they're active duty, guard, or reserve, because
15 with total force, of course, it's all the same
16 thing. And so I think we're poised in the country
17 at least of being able to capitalize on that
18 greater awareness so that the returning troops and
19 their families and their faith communities and
20 their social clubs and their employers as well as
21 the Department of Defense and the Veterans
22 Administration are in a better position today to

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

288

1 respond quickly and therapeutically to our
2 veterans as they return back to civilian society
3 than we were or could possibly have been in --
4 from 1968 to 1982 really.

5 SPEAKER: Again, Bob, thank you. I will

6 now go into an administrative session, and I'll
7 ask the core Board and subcommittee members, the
8 ex-officio members, the DHB staff, and the service
9 liaisons to remain, and ask the remainder of the
10 group to go ahead and depart. The open session
11 will start tomorrow at 8:30 with registration.
12 We'll try to start right on time tomorrow, and
13 we'll see you then. So thank you and otherwise,
14 the Board is adjourned.

15 (Whereupon, at 4:30 p.m., the
16 PROCEEDINGS were adjourned.)

17 * * * * *

18

19

20

21

22

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190